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ABSTRACT

The purpose of this annotated bibliography and of the project of which it is a part is to aid decision-makers in the continuing education of health manpower. The bibliography is divided into four major categories and numerous minor divisions reflecting four interrelated aspects of continuing education for health manpower. The first covers the scope and levels of the subject; the second deals with adult and continuing education; and the third is on preparatory education; and the fourth is about health care services. There are 440 items, 59 of which are other bibliographies or literature reviews. There are some cross references to show relationships. The items are all in English. All annotations are attributed. There is an author index at the end of the bibliography and an organizational subject index at the beginning. (MS)

A BIBLIOGRAPHY FOR CONTINUING EDUCATORS OF HEALTH MANPOWER

PROJECT CONTINUING EDUCATION FOR HEALTH MANPOWER

Performed by Syracuse University, Syracuse, N.Y.
Pursuant to Contract No. HSM 110-71-147 with
The Regional Medical Programs Service
The Public Health Service
The Department of Health, Education, and Welfare

Project Director: Alexander N. Charters, Professor and Area Chairman, Adult Education, Syracuse University

Principal Investigator: R.J. Blakely, Adjunct Associate Professor, Adult Education, Syracuse University

PART TWO OF FOUR PARTS A Selected Annotated Bibliography for Continuing Educators for Health Manpower

Part One: Fostering the Growing Need to Know

Part Three: A Report of Some Significant Activities in Continuing Education for Health Manpower in the United States

Part Four: A Critique of Descriptors of Terms in Continuing Education for Health Manpower

July 1973

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STATEMENT

This publication is one of four parts of the Project Continuing Education for Health Manpower performed by Syracuse University pursuant to Contract No. HSM 110-71-147 with the Public Health Service, Department of Health, Education, and Welfare. The four parts are *Fostering the Growing Need to Learn: Designs for the Continuing Education of Health Manpower; A Selective Annotated Bibliography for Continuing Educators of Health Manpower; A Report of Some Significant Activities in Continuing Education for Health Manpower in the United States; and A Critique of Descriptors of Terms in Continuing Education for Health Manpower.* We take responsibility for these products, with full acknowledgement of the contributions of many persons to whatever usefulness the results may have to continuing educators in the health manpower field.

The Project staff acknowledges, first, the contributions of Dr. Marian E. Leach, Head, Education Science Section, Continuing Education and Training Branch, RMPS. She and the Project Director had many hours of discussion of the needs of the field of continuing education for health manpower before an enterprise to try to meet some of them took shape. During these discussions it was decided that at various stages of the study, the Project staff and the RMPS staff and advisors they would appoint would meet face-to-face to review not only the substance but also the next steps. In the Foreword to this volume, Dr. Edward Hinman remarks that the contract was unique in that it "incorporated provision for process as well as product." In that process, Dr. Leach participated as Project Officer and she also contributed as a highly professional and widely experienced continuing educator to every product at every stage.

In her Preface Dr. Leach acknowledges the contributions of the *Ad Hoc* Group that advised the RMPS on the monographs that make up *The Growing Need to Learn.* The Project staff acknowledges its grateful indebtedness also to the persons who advised Syracuse University. At first we called the group an "advisory panel." There were three plenary sessions. But as the Project developed the help we sought and received became more flexible. There were many informal meetings with individual members and with others who were not at first formally on the "panel."

We acknowledge the special contributions to the entire project of the following persons:

Pauline Atherton, Professor, School of Library Science, Syracuse University
Robert D. Bergeron, Director of Education, The Connecticut Hospital Association
Cyril O. Houle, Professor, Adult Education, University of Chicago
Ernest McMahon, Dean Emeritus, University Extension, Rutgers University
Rolf Monge, Associate Professor, Psychology, Syracuse University
Margaret Sovie, Educational Director, Upstate Medical Center, State University of New York
Coolie Verner, Professor and Department Chairman, Adult Education, University of British Columbia

At various times the staff and panel were assisted by the following persons:
Harlan Copeland, Associate Professor, Adult Education, Syracuse University
Doris Chertow, Editor of Publications in Continuing Education, Syracuse University
Stanley Grabowski, Director, ERIC Clearinghouse on Adult Education
Betty Jane Vaughn, Director, Library of Continuing Education, Syracuse University.

Alexander N. Charters,
Project Director,
Professor, School of Education

R. J. Blakely,
Principal Investigator,
Associate Professor (Adj.),
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INTRODUCTION

This is a bibliography "for continuing educators of health manpower"; it is not just a bibliography "of continuing education of health manpower" – although 221 of the total 440 items are precisely that. The distinction is important because it governs not only the items selected but also the annotations and the organizational structure. The distinction derives from the purpose of the bibliography.

The purpose of the bibliography and of the project of which it is a part is to aid decision-makers in the continuing education of health manpower. Continuing education, which includes training, is defined pragmatically as systematic efforts to acquire, maintain and develop the abilities, skills, knowledge and attitudes of persons already engaged in providing health care so they can do their jobs or fill their roles better. The field of health manpower is vast and varied – ranging from the specialist physician to the previously untrained employee, from the lay board member to the volunteer aide. The situations in which health care is provided are many and varied – ranging from the hospital and clinic to the physician's office and the patient's home.

Many persons in many positions make decisions about continuing education of health manpower. Some of them are the planners, policy-makers and managers who make decisions about health care and health-care delivery, for whom continuing education is, or could be, a major strategy for improvement. Others are the actual providers of health care, for whom continuing education is, or could be, a major means for better performance. Still others are persons who have direct responsibilities for planning, implementing and evaluating the actual continuing education activities – for other persons, for themselves, or (ideally) for both. Most of all these several kinds of persons lack professional preparation in education; many who have had such professional preparation lack assurance that it fits them for their responsibilities. Almost all these persons in all these positions or roles lack a rationale that links continuing education and training efforts to efforts to improve health care and health-care delivery. The Project Continuing Education for Health Manpower is intended to help fill these lacks.

The purpose of the Project was to make a critical study of continuing education activities in the field of health manpower in the United States in order (1) to describe a scientific basis and a conceptual framework for continuing education efforts, and (2) to document continuing education of health manpower in a systematic way that would help decision-makers avoid traditional pitfalls, encourage sound innovations, and replicate and advance successful efforts.

The Project was to result in a set of five instruments: (1) a model, or models, applicable to a wide range of practitioners representing various disciplines and responsibilities in the provision and delivery of health care; (2) a series of monographs commissioned from outstanding authorities that together would cover all the key aspects of continuing education of health manpower; (3) an annotated bibliography for continuing educators of health manpower that also would cover all the key aspects of continuing education of health manpower; (4) a report of some significant activities in continuing education of health manpower throughout the country; and (5) a thesaurus of descriptors of terms (a controlled vocabulary) for the storage and retrieval of the literature of continuing education of health manpower. These five instruments were conceived as a set -- all of which would serve to generate the understanding necessary for a rational, articulated, programmed development of continuing education of health manpower.

(The five instruments became four, when the Model was combined with the series of monographs.)

The methods of the Project were (1) to search the literature of continuing education generally and of continuing education of health manpower specifically, especially pertaining to the Regional Medical Programs – using such resources as the National Library of Medicine (particularly its MEDLARS), the Educational Resources Information Centers (particularly the ERIC Clearinghouse on Adult Education), the Syracuse University Library of Continuing Education, and the Library of the Upstate Medical Center of the State University of New York; and (2) to consult with knowledgeable persons in various institutions, disciplines and practices, by engaging in dialogues, making visits to sites of activities and attending meetings.

The process of the Project deserves note. The contract incorporated provision for process as well as for product. It was designed to be highly interactive. The Project Officer, Dr. Marian Leach, and the Principal Investigator, Mr. Robert Blakely, worked closely together through a cooperative process utilizing an *ad hoc* group of consultants called together by the Regional Medical Programs Service, and a Syracuse University panel of adult education consultants under the leadership of Dr. Alexander Charters, Project Director.

Before we turn attention to the present bibliography, a report on each of the five instruments of the Project is in order. What was referred to as "The Model" has become the first chapter in a book; what was referred to as a "series of monographs" has become the other nine chapters of that book: *Fostering the Growing Need to Know,* which is a companion volume to the present bibliography.

A Report of Some Significant Activities in Continuing Education for Health Manpower in the United States has been submitted to the Regional Medical Programs Service.

A Critique of Descriptors of Terms in Continuing Education of Health Manpower (a list of descriptors of terms) has been submitted to the Regional Medical Program Service.

The fourth instrument, of course, is the present bibliography.

THE ORGANIZATION OF THIS BIBLIOGRAPHY

The organization of the bibliography derives from the purpose of the project – to aid decision-makers in the continuing education of health manpower – and from the nature of the field of continuing education of health manpower. That field is made up of at least four contiguous areas, or (to change figures) it has at least four interrelated aspects.

The first aspect is the continuing education of health manpower, with all the scope and variety of levels, kinds and situations that have been noted.

The second aspect is the continuing education of adults,* which is a discipline of study and a field of activity with a steadily developing body of theory and practice concerning learning by and instruction of adults; as a field of study it has recently begun to develop a concern for comparative adult education – both comparative between activities in various nations and comparative between activities in various fields, particularly professional and vocational fields.

The third aspect of concern for continuing education of health manpower is education preparatory for work in the health services – primary, secondary, vocational and technical, and professional; continuing education of health manpower must be concerned with preparatory education (or its lack) both because it has been the "starting point" for persons already engaged in providing health services and because certain developments in preparatory education (some of which are under way) would make the tasks of continuing education of health manpower much easier – particularly those that emphasize problem-solving; and the attitudes, ideas and practices of self-directed, life-long education. Conversely, the development of a scientific rationale and effective practices in continuing education of health manpower could have (and already is beginning to have) powerful beneficial influences upon preparatory education.

The fourth aspect of continuing education of health manpower is health care and health-care delivery. Continuing education for health manpower

*There is no generally accepted agreement on a distinction between the terms "adult education" and "continuing education." Historically "adult education" has had connotations of remedying lacks or making up deficiencies. Recently "continuing education" has come into frequent usage to connote the educational activities of highly prepared and effective persons to maintain and advance their competencies. But the distinction is not made in this bibliography. "Adult education" and "continuing education" in the literature are often used synonomously and sometimes together as "adult and continuing education."

must be concerned with this vast and complex area, or aspect, because the primary purpose of continuing education of health manpower is to improve health services -- both the quality of care and the delivery of care.

Consequently the bibliography is divided into four main categories (1) CONTINUING EDUCATION OF HEALTH MANPOWER, (2) ADULT AND CONTINUING EDUCATION, (3) PREPARATORY EDUCATION, and (4) HEALTH-CARE SERVICES. These main categories are broken down, in some places minutely. This device was judged to serve the purposes of showing relationships in a way that a traditional subject-matter or professional-vocational-job organization would not. Such organization based upon aspects and their relationships, and various kinds of progression within each subdivision ruled out a listing of items according to the alphabetical order of authors, of course.

GENERAL COMMENTS

A bibliography covering so vast a field with so many aspects had necessarily to be sharply selective. An attempt was made to compensate for the necessary exclusions by the inclusions of many other bibliographies and reviews of literature – a total of 59 (more than 13 per cent of the total 440 items) – listed at the appropriate places.*

One of the purposes of the bibliography -- to describe a scientific basis and a conceptual framework for continuing education efforts in a way applicable

*Health Manpower Planning, No. 9; Continuing Medical Education, No. 24; Continuing Education in the Health Professions, Nos. 36 and 37; Training and Methodology, Nos. 122-128; Learning and Cognitive Performance in Adults, No. 223; Self-Concept in Adults, No. 227; Research in Adult Education in the United States, Nos. 235-245; Continuing Education in the Professions, Nos. 262 and 263; Community Development in Urban Areas, No. 278; Community Services and Continuing Education, No. 279; Needs of People and Their Communities, No. 281; Use of the Telephone in Adult Education, No. 284; Use of the Computer in Adult Education, No. 285; Evaluation Models, No. 287; Cost-Benefit in Adult Education, No. 288; Career Ladders and Lattices, No. 297; Health Occupations Education, No. 302; Research in Technical Education, No. 303; Analysis for Curriculum Development, No. 304; Listing of Materials for Health Occupations Education Available from Federal Agencies, No. 312; Literature on Residential Schools in Vocational and Technical Education, No. 314; Recurring Bibliography in the Allied Health Professions, No. 327; Poverty and Health in the United States, No. 335; Community Health Services: Publications Catalog of Activities and Programs of the Community Health Services and Other Governmental and Nongovernmental Organizations, No. 339; Health Care Variables, No. 340; Health Services Research Bibliography, No. 341;Evaluation of Health Programs, No. 343; Methodology in Evaluating Quality of Medical Care, No. 344; Selected List of References on Quality of Medical Care Assessment, No. 345; Changes in Education, No. 355; Emergency Health Services, No. 375; Planning for Locational Change in Development of Health Care, No. 376; Periodicals for Health Planning, No. 377; Community Health Planning, No. 378; Comprehensive Planning for Health and Related Topics, No. 379; Consumer Participation, No. 383; Government Role in Financing Medical Care, No. 388; Government Role in Financing Dental Care, No. 389; Health Care Organization, No. 402; Functional Job Analysis, No. 414; and Equivalency and Proficiency Testing, No. 419.

to a wide range of practitioners representing various disciplines and responsibilities in the provision and delivery of health care called for stress on interrelationships and commonalities. Consequently there are more items under "sponsorship of programs" – including self-sponsorship and cooperative sponsorship – than there are listed under particular professions and vocations (51 items compared to 37). Consequently also the items under the common components of the continuing education process make up almost exactly half (110 of 221) of the first category CONTINUING EDUCATION OF HEALTH MANPOWER.

There are some cross-references to show relationship between categories. For example, Item No. 25, *An Abstract for Action,* listed under Nurses, and Item No. 103, "From Abstract into Action," listed under Cooperative Sponsorship of Programs, are cross-referenced. So are Item No. 393, *Area Health Education Centers,* listed under The Regional Approach, and Item No. 406, *Higher Education and the Nation's Health Policies for Medical and Dental Education,* listed under Increasing Supply of Health Manpower.

Obviously various items could have as reasonably been included in subunits other than the ones in which they are listed. For example, the five items on "peer review" (Nos. 165-169) could have been included under HEALTH-CARE SERVICES – Assessment of Quality of Health Care, but instead are included under CONTINUING EDUCATION OF HEALTH MANPOWER – Data Bases and Their Uses, because this bibliography stresses the educational uses of peer review.

Four items are put under two categories each (with the annotations following the first citations): No. 79, *Training and Continuing Education: A Handbook for Health Care Institutions,* and No. 80, *Continuing Medical Education in Community Hospitals: A Manual for Program Development,* are included first under 1.9 "Health-Care Institutions Sponsorship of Programs" and again under 1.110 "Components of the Continuing Education Process – Overview." No. 228, *The Design of Education,* is included first under 2.2, ADULT AND CONTINUING EDUCATION – General, and again under 2.5, ADULT AND CONTINUING EDUCATION – "Components of the Continuing Education Process." No. 394, "The Delivery of Health Care," is included first under 4.9 "Health Maintenance Organizations," and again under 4.13 "Better Use of Health Manpower." The reason for these double entries and for the cross-referencing is, to repeat, to strengthen the stress on relationships that the bibliography seeks to reveal.

This bibliography, like the other products of the Project, is intended primarily for practitioners. Thus it is heavy with guides, guidelines, guidebooks, handbooks, reference books, catalogues, studies, surveys and reports. However, it is not exclusively for practitioners. It has many bibliographies and reviews of the literature on research and on methodologies, and it has a number of highly philosophical or analytical items. For example, No. 17, *The Doctrine of Signatures: A Defense of Theory in Medicine;* Item No. 342,

"Five Approaches for Assessing the Quality of Care"; and Item No. 380, "Citizen Participation Strategies."

The items are all in the English language and most are about the United States, with some from Canada and a few from Great Britain. (Item No. 36, *Continuing Education in the Health Professions: A Review of the Literature 1960-1970,* includes the literature of Canada as well as that of the United States.)

The inclusions, exclusions, organization and emphases all reveal underlying judgments, of course. For example, they reveal preferences for the "process model," for the problem-solving approach, for the establishment and uses of data bases, for basing continuing education programs upon demonstrated need, for the work context, for self-directed learning, for evaluation – particularly program evaluation that relates educational objectives to institutional goals – for the "team" approach, and for cooperative planning and utilization of resources.

SPECIFIC COMMENTS

A number of the annotations are used as occasions for miniature reviews of the literature and miniature bibliographies. For example, Nos. 130-148, *The Problem-Oriented System,* and Nos. 235-245 on *Research and Investigation in Adult Education in the United States.*

Moreover, a number of the annotations go beyond the particular item to call attention to a wider range of activities or newer developments. For example, No. 61, The American Society of Clinical Pathologists; No. 62, the California Medical Association; No. 63, the Postgraduate Medical Institute; No. 64, the American Medical Association; No. 79, the American Hospital Association, with its affiliates the Hospital Research and Educational Trust, and the American Society for Hospital Education and Training; No. 181, the National Library of Medicine; and No. 182, the Lister Hill Center for Biomedical Communications. In each case, the additions are indicated by paragraphing, and/or the references are to further sources of information rather than to an article or book.

In a few cases, activities are included without citing a specific article or book – either because there is none up to date (e.g., No. 190, MIST), or because no account has yet appeared (e.g., No. 193, "MediCall"), or because there is no adequate generally published account (e.g., No. 129, Professional Activities Study and Medical Audit Program – PAS-MAP). In such cases, names and addresses for information are given rather than citations to literature.

Even though they include only two, three or four items, a few subheadings are included because of their extraordinary importance and their early stages of development. For example, Item No. 221 on "accountability" and Items 403-404 on "assessing cost-benefit" in the health field.

Of the 424 annotations (16 bibliographies are cited without annotation), all are attributed. Nearly 72 per cent were written by members of the Project staff, indicated by their initials: RJB – R.J. Blakely; MAP – Maria A. Pafundi; and LY – Lloyd Young. Nearly 24 per cent were borrowed from Educational Resources Information Center/Adult Education, indicated by ERIC. Of the remaining 5 per cent, nine were borrowed from the *Journal of the American Hospital Association*, indicated by JAHA; two from the *American Journal of Nursing*, indicated by AJN; one from the *Journal of the American Dental Association*, indicated by JADA; three from the *New England Journal of Medicine*, indicated by NEJM; four from the National Technical Information Service, indicated by NTIS, and one each from the *Annals of the American Academy of Political and Social Sciences*, the Health Services Research Center, and *Lancet*, in which cases the sources are indicated by context.

To conclude, attention is called again to the companion volume to this bibliography: *Fostering the Growing Need to Learn*. The ten chapters in that volume set forth the conceptual scheme and rationale that underlie this bibliography, and, in turn, this bibliography amplifies the ideas and information included in that volume. Each of the ten chapters of that volume has references and some also have further recommended readings. Those references and recommended readings should be considered a supplement to this bibliography, particularly the references and recommended readings following the chapters by Alan Knox, Leon Lessinger, Ann Lewis and Ruth Roemer.

ANC
RJB

Note on Indices:

There is an author-index at the end of the bibliography.

Instead of a subject-index at the end, there is at the beginning a detailed organizational index, to show relationships.

Because of the complexity of the organization of this bibliography, each subunit is introduced with a visual device – like a large-scale map insert and in the corner of a small-scale map. For example:

1 CONTINUING EDUCATION OF HEALTH MANPOWER

1.11 **Components of the Continuing Education Process**
1.114 **Evaluation**

2 ADULT AND CONTINUING EDUCATION
3 PREPARATORY EDUCATION
4 HEALTH-CARE SERVICES

This device is intended to help the user keep in mind where each item is in the organizational structure.

ORGANIZATIONAL INDEX

1. CONTINUING EDUCATION FOR HEALTH MANPOWER

1.1 Health Manpower, General

2. ADULT AND CONTINUING EDUCATION
3. PREPARATORY EDUCATION
4. HEALTH-CARE SERVICES

1. LECHT, Leonard A. *Manpower Needs for National Goals in the 1970's.* Frederick A. Praeger, N.Y., 1969. 129 p.

This study was undertaken by the National Planning Association's Center for Priority Analysis to provide more and better information concerning national goals and resources to decision-makers. It is a sequel to NPA's study of the dollar costs of achieving national goals in the '70's. The projections refer to the employment requirements that would arise if in the next ten years Americans tried to achieve all their priority goals. Lecht and colleagues maintain that there will not be enough manpower to achieve all that the American people and the American government regard as desirable; hence the need to utilize manpower resources to the full. Another major finding is that the kinds of jobs and the probable "manpower bottlenecks" are significantly influenced by the nation's choice of priorities; hence the urgent need to determine priorities. (MAP)

2. HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION. National Center for Health Statistics (DHEW). *Health Resources Statistics: Health Manpower and Health Facilities, 1969.* G.P.O., Washington, D.C., 1970. 272 p.

Intended to provide current statistics on health manpower and inpatient health facilities for the evaluation, planning and administration of health programs, data were gathered from college and university records, state licensing records, association membership records and agencies and establishments that provide health services. About 3.7 million persons were employed in 1968 in 34 health professions and occupational areas identified in this publication. Nursing and related services were the largest category of employed persons, followed by medicine and osteopathy, secretarial and office services, and dentistry and allied services. There were an estimated 31,000 inpatient health facilities in the United States, with 63 percent nursing care and related homes, 26 percent hospitals, and 11 percent sheltered care facilities. This represents an estimated increase of 3,800 inpatient health facilities, or 14 percent, since 1963. These and other data are provided in textual and tabular form. A list of health occupations is appended. (ERIC/SB)

3. GREENFIELD, Harry I. *Allied Health Manpower.* Columbia Univ. Press, N.Y., 1969. 195 p.

The purpose of this book is to view comprehensively the manpower dimensions of American medicine today with a focus on the more than 1.7 million health workers referred to as "allied health manpower." This group includes five categories of technicians: X-ray, medical records, occupational and physical therapy, medical and dental; and three categories of assistants – practical nurses, nurse's aides, and psychiatric aides. The authors sees major obstacles to quality improvement in the form of makeshift training programs, fast turnover, licensing requirements, professional barriers to upgrading, and poor personnel management. He thinks that improvement in the recruitment, training and utilization of allied health manpower can come about only through a variety of innovative changes at many different levels of the health-care system. This is an important book for hospital administrators and inservice educators, with its factual overview and thoughtful guidelines for research and improvements. (MAP)

4. LOSEE, Garrie J. and ALTENDEFER, Marion E. *Health Manpower in Hospitals.* National Institutes of Health, Bureau of Health Professions Education and Manpower Training (DHEW), Bethesda, Md. 1971. 88 p.

This is the first in a series of Division of Manpower Intelligence (DMI) reports designed to contribute to a better understanding of health education and training. This report presents a national and regional estimate of the numbers of professional, technical, and other personnel employed in hospitals in the United States. Number of employees, budgeted positions vacant, and additional current manpower needs are reported by occupational category of personnel and by ownership and type of hospital. The primary focus of the statistics and analyses in this report is on community hospitals which made up approximately 6,500 out of an estimated 7,930 hospitals in 1969. Future reports will present the results of more detailed analyses of levels of staffing and of needs. (ERIC/GEB)

5. NATIONAL COMMITTEE FOR CAREERS IN MEDICAL TECHNOLOGY. *Manpower for the Medical Laboratory: The Proceedings.* G.P.O., Washington, D.C. 1968. 130 p. Public Health Service Publication No. 1833. National Conference on Education and Career Development of the National Committee for Careers in Medical Technology.

This report of an interdisciplinary conference on "Manpower for the Medical Laboratory" deals with personnel below the level of laboratory director–the three categories of medical technologists, cytotechnologists, and laboratory assistants–as well as other professional and allied staff members such as chemists, biologists, technicians and aides. The broad objectives of the conference were to examine laboratory personnel requirements as affected by changes in the health-delivery system; to examine the effects of technology on laboratory personnel needs; to examine the recruitment, training, certification and licensure of personnel and schools. Conference topics included: the life-long education of the medical laboratory professional, the supply and demand of personnel, and health legislation affecting medical laboratory manpower. (MAP)

6. BERG, Ivar. *Education for Jobs: The Great Training Robbery.* Praeger Publishers, N.Y., 1970. 219 p.

Berg's study, based on extensive data, challenges some conventional assumptions about the relationship between education and jobs - many workers are overeducated for their jobs; salaries are not necessarily closely related to education; many teachers and social workers earn less than plumbers and professional athletes; an employee's productivity does not vary systematically with his years of formal education; the rate of turnover is positively associated with high education. Among workers in lower-skilled jobs, dissatisfaction increases as educational levels rise. Better educated employees are often rated as less productive. The practice of basing teachers' salaries on credits they earn toward higher degrees actually encourages teachers not to teach since those who feel overtrained tend to seek administrative positions or better-paying jobs in industry. In the armed forces high-school graduates are not uniformly and markedly superior to nongraduates and training on the job is more important than educational credentials. Berg asserts that it is fundamentally subversive of education and democratic values not to see that, in relation to jobs, education has its limits. The crucial employment issue is the overall level of employment and the demand for labor in a less than full employment economy. (ERIC/NL)

7. MANPOWER ADMINISTRATION (DOL). *Health Careers Guidebook.* Revised edition. G.P.O., Washington, D.C. n.d. 251 p.

The National Health Council produced this health Occupations guidebook for students, their parents, counselors, and educational advisors. The first part gives an overall view of the health field. The second examines individual health careers in regard to what the occupation is and does; why it is important; what the personal, aptitudinal, and educational requirements are; and what health partnerships and related health occupations exist. There is also a list of organizations that supply information on particular health occupations and on college and career planning. (MAP)

8. ODGERS, Ruth F., and WENBERG, Burness G., Editors. *Introduction to Health Professions.* C. V. Mosby Co., St. Louis, Mo. 1972. 189 p.

This provides educational and occupational information for 20 health careers, showing how the health professional functions in his job, what education and training is needed, and what employment opportunities are available. Written by practitioner-educators, the book can be used for vocational counseling in undergraduate colleges and secondary schools. The health-career areas discussed are: medicine, dentistry, optometry, veterinary medicine, nursing, pharmacy, physical therapy, dental hygience, dietetics, inhalation therapy, medical record administration, medical technology, occupational therapy, radiologic technology, speech and hearing science, medical social work, hospital and health services administration, medical communications, medical illustration, and environmental sanitation. (MAP)

9. BROWN, Monica V. and HARTEN, Carol J. *Health Manpower Planning Bibliography.* Council of Planning Librarians, Monticello, Ill. 1970. 17 p. Exchange bibliography #134.

This selective bibliography was prepared by the Director of Health Manpower Projects, Ohio State Regional Medical Program and the Coordinator of Continuing Education Programs, Graduate Department of Community Planning, University of Cincinnati, for a workshop on "Health Manpower Planning." It includes documents on health professionals; paraprofessionals; manpower needs; distribution and utilization; the geographic, social, educational and ethnic considerations of health-manpower planning; and the descriptive, analytic, and projective methods of planning. (MAP)

1. CONTINUING EDUCATION FOR HEALTH MANPOWER

1.2 Continuing Educators of Health Manpower

2. ADULT AND CONTINUING EDUCATION
3. PREPARATORY EDUCATION
4. HEALTH-CARE SERVICES

10. DICKINSON, Gary. *A Survey of the Need for Programs to Prepare Members of the Health Professions as Specialists in Continuing Education.* Univ. of British Columbia, Vancouver, B.C., Canada. 1972. 20 p.

Through a W.K. Kellogg Foundation grant, the Adult Education Research Centre and the Division of Continuing Education in the Health Sciences at the University of British Columbia conducted a survey to assess the need for specialized programs to prepare members of the health professions to organize and conduct continuing education. A questionnaire was sent in January 1971 to health-science professionals (in medicine, nursing, dentistry, and pharmacy) in the United States and Canada. Several conclusions emerged from the survey: A high level of need for programs of professional preparation in continuing education for the health sciences was expressed in each of the major fields; several types of programs–graduate, short courses, and individualized instruction–are needed; emphasis should be on the practical application of principles related to adult learning, instruction, and program design; financial support from non-university sources is required to enable the greatest number of persons to participate.

The Department of Adult Education and Division of Continuing Education in the Health Sciences, University of British Columbia, have established a program for the professional preparation of specialists in continuing education in the health sciences. Funded by the W.K. Kellogg Foundation in 1971, by 1973 the program had graduated three persons with master's degrees, held an international conference (see Item No. 98) was planning a second international conference in the summer of 1973, had begun a mobile resource center and had developed four bibliographies of continuing education in the health professions. (See Item No. 36) (RJB)

11. CAMPBELL, Albert B. "The Adult Educator in the Hospital Setting". *Adult Leadership.* April 1971. pp. 331-2; 355.

Campbell sees the adult educational specialist in a hospital as beset with problems of keeping pace with a rapidly-moving technology, adjusting to the new concepts of the relationship of the hospital to the community, and curbing the high cost of staff inefficiency and excessive employee turn-over. He offers guidelines: the establishment of a department of education independent of the personnel department, the selection of an educational director who has special background knowledge in adult education, the creation of a meaningful orientation program, the establishment of continuing inservice programs by working with the medical professions and other specialties, and the development of programs for patients and their families to cope with the hospital environment and new relations. (MAP)

12. MILLER, George E. "Continuing Education for the Health Professions". *Journal of the American Physical Therapy Association.* May 1967. pp. 418-424.

In 1966 a University of Illinois task force on continuing medical education sought to determine ways in which the health professions might cooperate in developing continuing education programs with a higher probability of improving patient care than conventional efforts directed toward separate professions. The majority of existing medical continuing education programs appeared to be information- and skill-oriented rather than patient-centered; professional meetings and courses and specialized literature were proliferating; uses of new educational technology were still quite conventional; and, while programs within professions were vigorous and varied, interprofessional efforts were sparse and paltry. Cooperation among the health professions was probably impeded by differences arising from educational patterns and health-care objectives, and by rigid perceptions of professional roles and prerogatives. However, it was found that, with a common problem and opportunity for joint inquiry into its solution, interaction occurred and favorable attitudes developed. A sequential program was suggested that would entail joint study of patient needs, evaluation of suitable measures, self-evaluations of performance, and action to meet the defined needs. (ERIC/LY)

13. ASSOCIATION OF HOSPITAL DIRECTORS OF MEDICAL EDUCATION. "The Director of Medical Education in the Teaching Hospital: A Revised Guide to Function". *Journal of the American Medical Association.* June 21, 1965. pp. 113-118.

This first revision of the Guide, originally published by the Association of Hospital Directors of Medical Education (AHDME) in 1961, aimed at hospitals contemplating the appointment of a director of medical education and at physicians considering such a job. The descriptive terms are broad enough to apply to most hospitals with internships or residency programs and without major medical school affiliations. The Guide considers the director of medical education as "a new career in medicine." It describes the professional and personal qualifications that the director should have, his position (including appointment and rank, his dual responsibility to the trustees and to the professional staff, his salary and expenses, and the amount of time devoted to this position), and his functions as teacher, coordinator and

counselor. The Guide warns that a director of medical education cannot create an educational atmosphere. It says that a director should not even be considered until the leaders of the staff have convinced a majority of the practicing physicians that they must have a continuing interest and responsibility in the educational program (MAP)

14. COMMISSION ON MENTAL ILLNESS AND RETARDATION. *Physician's Digest for Continuing Psychiatric Education Programs.* Southern Regional Education Board, Atlanta, Ga. n.d.

The Southern Regional Education Board publishes the *Digest*, which is designed for persons either planning to teach or teaching in education programs in psychiatry for physicians; however, many of the items are useful to other health manpower educators. It pulls together from the literature and various people's experiences the most useful points that bear on facets of continuing education for physicians. It is not published at regular intervals but is prepared when there is enough content material available on a single topic in continuing education in psychiatry. Some topics that have been discussed are: variations in patient management and how to determine physicians' educational needs in psychiatry; planning continuing education programs in psychiatry; the rural family practitioner and his needs for continuing psychiatric education; psychological aspects of adult learning; instructional theory and methods; programs in interpersonal dynamics; continuing psychiatric education for physicians with a predominantly pediatric practice. There is no subscription price. Single copies are available upon request or a complete set of back issues. For information about the project that sponsors the *Digest* or copies of it, write Harold L. McPheeters, M.D., Director, Commission on Mental Illness and Retardation, 130 Sixth St. N.W. Atlanta, Ga. 30310 (RJB)

1. CONTINUING EDUCATION FOR HEALTH MANPOWER

1.3 Physicians

2. ADULT AND CONTINUING EDUCATION
3. PREPARATORY EDUCATION
4. HEALTH-CARE SERVICES

15. CLARK, I.C. *The Development of Physician Continuation Education.* Univ. of Iowa. Graduate Program in Hospital and Health Administration, Iowa City, Iowa. 1966. 77 p.

This book recounts the postgraduate education of physicians as it has been recorded in medical literature, then it documents the need for programs of continuing education, leading to a description of the major structural innovations and methods of instruction delivery by some medical schools. Finally it sets forth some propositions concerning the future development of continuing education. It anticipates that colleges of medicine will give leadership and that these will be loosely linked into a "university without walls," as depicted in the Dryer Report (Dryer, Bernard V. "Lifetime Learning for Physicians." *Journal of Medical Education*, Vol. 37, Part 2, June 1962). The next to the last chapter sets forth a plan for the University of Iowa Medical Center in the continuing physician education of Iowa. (RJB)

16. MILLER, George E. "Continuing Education For What?" *The Journal of Medical Education.* April 1967. pp. 320-326.

Continuing medical education should mean continuing self-education, not continuing instruction–a shift away from preoccupation with courses and methods toward a concern for educational diagnosis and individualized therapy. Continuing education should lead practitioners to a study of what they do, to an identification of their own educational deficits, and to the establishment of realistic priorities for their own educational programs. One means of accomplishing this is to delineate the health needs of the population served by a practitioner or hospital staff, perhaps by weighting three variables: disease incidence, individual disability produced by these diseases, and social disruption, or the degree to which illness affects the family and related social units. Once health needs have been determined, an inventory of available resources can be developed. If it becomes clear that little can influence the outcome of a frequently encountered problem, educational attention can be directed to other things about which something can be done, while research continues on problems remaining to be solved. Practitioners also need to be involved in an analysis of their use of the available resources. (ERIC/AJ)

17. BUCHANAN, Scott. *The Doctrine of Signatures: A Defence of Theory in Medicine.* Harcourt, Brace and Co., N.Y. 1938. 205 p.

This philosopher spent two years of study "of medicine as the medium and perhaps the focus in which the problems of wisdom and science meet." The result is a book of metaphysics, in the sense of "beyond physics." "Metaphysics is inescapably present in all concrete and practical affairs, and the choice to ignore it is to see things darkly." "Medicine has been a body of knowledge with varying degrees of scientific clarity from the most ancient times. It has in this time built a very imposing tradition with more than the usual concentration of wisdom in it. Throughout the major portion of this time it was dominated by two men, one a philosopher (Aristotle), the other a physician (Galen). It is not likely that there is a more rich or important source for the recovery of lost insights than in the writings of these men." "It is only by a thorough education in the liberal arts that the quackeries and literal-minded stupidities in theory and practice can be raised with the subject matter to the rational level where medicine may be called scientific and professional. The first and perhaps the only essentially important thing that can be done to improve or even to preserve medicine at present is through the reconstruction of programmes of liberal education and the first certain proposition that can be laid down is that a liberal education consists in learning the theory and practice of the liberal arts." (RJB)

18. DRYER, Bernard V. "Lifetime Learning for Physicians: Principles, Practices, Proposal". *Journal of Medical Education,* Part 2. June 1962. 146 p.

Asserting that the continuing education of physicians is one of the most important problems in medical education today, that the gap between scientific knowledge and application is increasing, and that a national plan to mobilize the personal, community, regional, and national education resources for medical education is greatly needed, The Joint Study Committee in Continuing Medical Education investigated ways of dealing with these problems. The group proposed a "University Without Walls," in which the

curriculum would be designed with the guidance of general and specialty medical organizations, created in partnership with highly skilled communications and media specialists, and expressed in a variety of carefully chosen instructional materials. Faculty members would be experts selected from many teaching centers and organizations. The physician would be motivated to participate by the wide variety of subject matter, comprehensive coverage, topnotch faculty, and opportunities for self-evaluation. The easy availability of many varieties of technical resources in personal, hospital, and organizational libraries would make it easy for the physician to use materials at his own pace. The report includes appendices, charts or models for the "University Without Walls," a discussion of cost factors involved and of the research methods used, and an extensive bibliography. (MAP)

19. DRYER, Bernard V. "A Nationwide Plan for Continuing Medical Education: Pros and Cons". *Journal of the American Medical Association.* July 6, 1964. pp. 123-127.

    The author contends that "whenever the two interlocking goals of improved medical care and personal professional satisfaction are now being achieved by thousands of physicians we find daily, ongoing working models of both formal and informal educational opportunities which should be available to all physicians, everywhere, all the time, with a glance at a wristwatch or hospital wall clock." Dryer asserts that there are two fundamental reasons for a nationwide plan—one is that only a national partnership with ready access to our major medical resources can offer year-in, year-out strength to all which no one resource has separately; the other reason is that a nationwide plan can make use of behavioral-science experience and communication technologies. Dryer reviews six components of sound educational organization: the governing body, a faculty of excellence, a table of organization, the curriculum, evaluation, and distribution, and he applies them to a nationwide plan for continuing education as an answer to the maldistribution of carefully organized opportunities to learn on a regular, convenient, accessible basis. (MAP)

20. FAHS, Ivan J. and MILLER, Winston R. *Patterns of Continuing Education: Minnesota Physicians, 1968. Volume One and Two.* Northlands Regional Medical Program, St. Paul, Minn. 1968.

    This report by the Northlands Regional Medical Program draws up a profile of the Minnesota physician's current habits of continuing education, attitudes toward various types of continuing education activities, and interests in proposed programs of continuing medical education. A 25 percent random sample of Minnesota physicians (770) was selected and a mail questionnaire devised to get maximum response and maintain homogeniety of the sample. Volume One is a summary of the study and a description of the major findings. Volume Two is made up of six appendices: an outline of the study, an annotated bibliography of selected sources, a list of consultants, the methodology used in developing the questionnaire, a description of followup procedures, and a rationale for the questions. The results, based on 87.7 percent response, indicated that each physician devised his own method for continuing education; that all of the contacted physicians used multiple sources for keeping abreast of new developments; that medical journals and

books were the dominant source of information; and that Minnesota physicians were very active in continuing education activities. (MAP)

21. *Patient Care.* The Journal of Practical Medicine. Miller and Fink Publishing Corp., Greenwich, Conn.

This abstract is about the journal itself because not only does it deal extensively with continuing education but it is deliberately an instrument for continuing education. First published in January 1967, its objectives are: ". . .to help the family physician provide more effective and efficient care for his patients, day by day and on a continuing basis. It is intended for both current reading and continuing reference." It has four special features: "Express Stops"–short summaries "Flow Charts"–memory aids accompanying some major articles; "Patient Education Aids"–certain articles with messages written specifically for patients; and "Resource Files"–highly selected lists of supplementary reading, available on request, at no charge. Two of the best collections of articles on continuing medical education available anywhere are the *Patient Care* issues of May 15 and May 30, 1971. The journal is published (since January 1973) on the 1st and 15th of each month, except July, August and December, when just the issues of the first are published. The price is $1.00 a copy, $20.00 a year. It is published by Miller and Fink Publishing Corp., 165 Putnam Ave., Greenwich, Conn. 96830. (RJB)

22. PATIENT CARE. "Avoiding the Blind-Alley Approach to Keeping Up". *Patient Care.* May 30, 1971. pp. 17-27.

This is a summary of a roundtable discussion of the types of continuing education available, a brief survey of the relative merits of each, ways to choose the type that suits the individual physician best, and the common errors to be avoided. Participating in the panel were directors of continuing medical education representing medical schools, hospitals, the voluntary health agencies, the Regional Medical Programs; the editor of *Patient Care;* and two practitioners involved in continuing education. The discussion was directed at meeting the needs of the practicing physician. Its conclusions: Medical educators should identify the type of practice and plan relevant educational experiences; they should set objectives; the convenient educational offerings are not always the best; courses without purpose and continuity waste the physician's time. (MAP)

23. AMERICAN PSYCHIATRIC ASSOCIATION. *Psychiatric Education and the Primary Physician.* American Psychiatric Association, Washington, D.C. 1971.

This report is the second in a series of Task Force Reports by the APA. It was prepared by the association's Committee on Psychiatry and Medical Practice, intended "as a guide for those interested in planning programs of continuing education in psychiatry–to orient them to the general goals of the field, to summarize and review achievements to date, to identify issues that continue to be vexing problems, to describe specific methods and programs that have developed, and to indicate possible directions for future activities." Included is an outline of a step-by-step procedure for developing a program for postgraduate training in psychiatry. The outline might be adapted to continuing education programs in other fields. The guide is for physicians who work in

community health centers who are not psychiatrists but who need education in psychiatry. It is also for psychiatrists so that they can collaborate effectively with other physicians by learning about advances in other fields of medicine. Copies of Task Force Report #2 with the title given above, are available for $3.00 each from Publications Services Division, American Psychiatric Association, 1700 18th St., N.W., Washington, D.C. 20009. (RJB)

24. LLOYD, John S. and others. *A Selected and Annotated Bibliography on Continuing Medical Education and Other Subjects.* Division of Research in Medical Education, University of Southern California, School of Medicine. Los Angeles, Cal. July 1969. 30 p.

1. CONTINUING EDUCATION FOR HEALTH MANPOWER

1.4 Nurses

2. ADULT AND CONTINUING EDUCATION
3. PREPARATORY EDUCATION
4. HEALTH-CARE SERVICES

25. LYSAUGHT, Jerome P. *An Abstract for Action.* McGraw-Hill Book Co., N.Y. 1970. 167 p.

This is the report of a two-and-one-half-year study begun in 1967 by the National Commission on Nursing and Nursing Education to examine the changing practices and educational patterns in nursing today and the probable requirements in professional nursing over the next several decades. Some significant recommendations include: (1) that nurses be directly involved in health-manpower planning at all governmental and regional levels; (2) that promotion be granted on the basis of acquisition of knowledge and demonstrated competence in performance; (3) that health administrators promote excellence in nursing practice by providing sufficient staff, by discharging appropriate nursing functions, and by evaluating the nursing plan for care; (4) that local health-care facilities adopt continuing education programs and flexible employment policies; (5) that institutions for nursing education provide licensed practical nurses with career ladders leading to academic degrees and registered licensure; and (6) that all state licensure laws for nursing be revised to require periodic review of the individual's qualifications as a condition for licensure renewal. (See Item No. 103.) (MAP)

26. NATIONAL LEAGUE FOR NURSING. *Nursing Education–Creative, Continuing, Experimental.* National League for Nursing, N.Y. 1966. 62 p.

This is a collection of the papers presented at the NLN's 20th Conference of the Council of Member Agencies of the Department of Baccalaureate and Higher Degree Programs, held in Philadelphia, November 10-12, 1965. More than half are devoted to continuing education. Notable presentations include: "The Role of the College and the University in Providing Continuing Education"; "The Administrator's Responsibility for Continuing Education of Nurse Faculty Members"; "The Responsibility of the Faculty for Helping Young Students to View Continuing Education as a Way of Life"; and "The

Responsibility of the College or University for Continuing Education for the Inactive Nurse–Motivation for Reactivation." (MAP)

27. BROWN, Esther Lucile. *Newer Dimensions of Patient Care. Part II: The Use of the Physical and Social Environment of the General Hospital for Therapeutic Purposes. Part II: Improving Staff Motivation and Competence in the General Hospital. Part III: Patients as People.* Russell Sage Foundation, N.Y. 1961-1964.

Brown's monographs on patient care are landmark documents in the field of nursing and are important in the shift of health care from concentration on disease to consideration of the whole person. The first discusses the psychosocial factors of patients (e.g., the hospital environment, food, the patient's anxiety, visiting privileges) and suggests ways of dealing with these factors. In the second Brown contends that the hospital atmosphere is often cold and impersonal because the staff is given specific tasks as opposed to being given responsibility for the comprehensive care of patients. This is a discussion of how the psychosocial and economic needs of the patient can be harmonized with the objectives of the hospital for more effective and efficient use of manpower. The last monograph suggests that the extensive use of social and cultural data on an efficient, economic, easy-to-interpret fact sheet can alleviate the criticism that health professionals do not treat patients as people. (MAP)

28. COOPER, Signe Skott and HORNBACK, May Shiga. *Continuing Nursing Education.* McGraw-Hill Book Co., N.Y. 1973. 261 p.

Signe Cooper was in charge of the Wisconsin-wide program of continuing education for nurses from 1955 to 1971, now headed by May Hornback, who has been with Wisconsin-Extension since 1965. These two pioneers address their book to nursing faculty members responsible for continuing education in institutions of higher learning but do so in a way that makes it useful to others with similar responsibilities in associations and hospitals. Chapter 3, "Trends in Adult Education," was contributed by Burton W. Kreitlow, Professor of Adult Education, University of Wisconsin. (RJB)

29. McHENRY, Ruth W., Editor. *Ends and Means: The National Conference on Continuing Education in Nursing, 1970.* Syracuse Univ. Publications in Continuing Education, Syracuse, N.Y. 1971. 133 p.

The second National Conference on Continuing Education in Nursing was held at Syracuse University's Sagamore Conference Center, Raquette Lake, New York on October 5-8, 1970. This report, edited by Ruth McHenry, then Chairman of Continuing Education in Nursing, Syracuse University, contains a list of the 81 participants, the program, a summary of the recommendations from the first National Conference (held in Williamsburg, Virginia, in November 1969), edited versions of 10 presentations, summaries of group reports and proposals, and the final recommendations adopted by the general assembly of the conference.

This publication is No. 69 of the "Notes and Essays on Education for Adults" of the Syracuse University Publications in Continuing Education. Another series in the Publications is the "Occasional Papers." Both of these series were taken over in 1969 by Syracuse University from the Center for the

Study of Liberal Education for Adults, and the University is continuing them. Together–the CLSEA publications and the Syracuse University Publications in Continuing Education–include some of the most searching and groundbreaking publications in the field of adult and continuing education during the 1950s and 1960s, and are being regularly added to. For a list of available publications, write to Dr. Doris Chertow, 105 Roney Lane, Syracuse, N.Y. 13210 (RJB)

30. COOPER, Signe S., Editor. *Critical Issues in Continuing Education in Nursing.* Univ. of Wisconsin-Extension, Madison, Wisc. 1972. 147 p.

This is the report of the Third National Conference on Continuing Education in Nursing held in Madison, Wisconsin, October 18-22, 1971. The conference's objective was to provide registered nurses whose major responsibility is continuing education with an opportunity to discuss issues, share ideas and knowledge, and learn about new developments in the field. Important papers include: "Philosophies of Education–Implications for Continuing Education in Nursing", by Edith V. Olson; "Developing a Model for Consumer Health Education," by William L. Blockstein; "Continuing Education as a Requirement for Relicensure: What Are the Issues?" by Maura Carroll; and "Introducing the Continuing Education Unit," by Paul Grogan. Also included are reports on regional approaches to continuing education for nursing in the Western states, Midwest, North Central states, and New England. (MAP)

31. *Journal of Continuing Education in Nursing.* Charles B. Slack, Inc., Thorofare, N.J.

This journal is published bimonthly, Vol. 1, No. 1 dated May 1970. The editor-in-chief is Dorothy J. Hutchison, R.N., M.A., Associate Professor, Department of Nursing, Health Sciences Unit, University Extension, the University of Wisconsin. Among its purposes are "to report program designs and educational approaches which have proved effective. . ." and "to present experimental and innovative approaches which offer new and more promising routes to the adult nurse learner." It regularly features important documents, colleague exchange, educational opportunities and book reviews. Subscriptions in the U.S.A. and possessions are $18.00 for one year, $32.00 for two years, and $44.00 for three years. Single copies and back issues, when available, are $3.50. The address of the publisher, Charles B. Slack, Inc., is 6900 Grove Road, Thorofare, N.J. 08086. (RJB)

32. THURSTON, Hester I. "The Lengthened Line: Thrust–A Must". *Journal of Continuing Education in Nursing.* Sept./Oct., 1970. pp. 11-17.

Continuing education must become an integral part of the educational system to enable the nurses to keep up to date. The Kansas Regional Medical Program (KRMP) circuit courses for nurses is a big step in that direction. (ERIC/PT)

33. PUZZUOLI, David A. and FAZZARO, Charles J. *The Development of Telelecture and Associated Media Systems for the Improvement of Nursing Education in West Virginia.* West Virginia Univ., College of Human Resources and Education, Morgantown, W. Va. 1971. 90 p.

A feasibility study explored the use of the telelecture technique for continuing nursing education in the state of West Virginia. Telelecture is a

two-way amplified communications system designed to bring together individuals and/or groups by means of a regular telephone network. The results of the study showed that it is an effective technique which brought continuing education courses to nurses throughout the state. The nurses who were taught by the telelecture method performed as well on tests as nurses taught by conventional methods. In addition the cost per student of the telelecture method was less than the cost of traditional continuing nursing education programs. (ERIC/JY)

34. KOZLOWICZ, Grace H. "Milwaukee's NISE Organization". *Journal of Continuing Education in Nursing.* May/June 1971. pp. 35-38.

This discusses the onset and organization of Nursing Inservice Educators of the Greater Milwaukee Area (NISE). Objectives of the group are to assist inservice educators in their professional growth and development by promoting the sharing of ideas among inservice educators in health facilities in the greater Milwaukee area and by identifying mutual problems and providing an opportunity for arriving at solutions. (ERIC/Author/RB)

35. JOURNAL OF CONTINUING EDUCATION IN NURSING. "Landmark Statement for California: Assembly Bill No. 449". *Journal of Continuing Education in Nursing.* Sept./Oct. 1971. pp. 28-31.

California Assemblyman Duffy's bill, now passed into law and effective 1977, requires of registered nurses and licensed vocational nurses participation in continuing education programs in order to renew their licenses. The licensee must show that in the preceding two-year period she (or he) has informed herself of recent developments in nursing by taking part in approved courses or by other equivalent means. In lieu of submitting proof, she may take a qualifying exam. The law also has provisions for dealing with reinstating those whose licenses have lapsed, and exemptions (overseas military service); there is a provision to establish a multi-disciplinary Council on Continuing Education for Health Occupations (effective July 1, 1972) to implement the law's requirements. The continuing education requirement is waived for the first two years following graduation from a nursing program. (MAP)

1. CONTINUING EDUCATION FOR HEALTH MANPOWER

1.5 Other Professions and Occupations

2. ADULT AND CONTINUING EDUCATION
3. PREPARATORY EDUCATION
4. HEALTH-CARE SERVICES

36. NAKAMOTO, June and VERNER, Coolie. *Continuing Education in the Health Professions: A Review of the Literature 1960-1970.* ERIC Clearinghouse on Adult Education, Syracuse, N.Y. 1973. 329 p.

June Nakamoto, R.N., and Coolie Verner, Professor of Adult Education, the Adult Education Research Centre and the Division of Continuing Education, University of British Columbia, have compiled four bibliographies of

continuing education in the health professions, as one of the activities of the program for the professional preparation of specialists in continuing education in the health sciences. (See Items No. 10 and 98.) The bibliographies are "Continuing Education in Medicine" (W.K. Kellogg Foundation Project Report No. 3), "Continuing Education in Nursing" (W. K. Kellogg Foundation Project Report No. 4), "Continuing Education in Dentistry" (W.K. Kellogg Foundation Report No. 5), and "Continuing Education in Pharmacy" (W.K. Kellogg Foundation Project Report No. 6). These four bibliographies have now been published in one volume by the ERIC Clearinghouse on Adult Education. (RJB)

37. LEYASMEYER, Edith and WHITMARSH, Laurie A. *Continuing Education in the Health Professions: An Annotated Bibliography.* Northlands Regional Medical Program, Inc., Saint Paul, Minn. 1969. 69 p.

    This annotated bibliography is a representative selection of 148 published works on continuing education for health professionals, with a particular focus on physicians. Its purpose is to compile information about the theory, practice, and evaluation of continuing education for the busy practitioner or instructor. (ERIC/CK)

38. WILLIAMS, Donald A. "Continuing Medical Education for the Health Team". *Proceedings, National Conference of State Medical Association Representatives on Continuing Medical Education, Chicago, Ill.* Nov. 12-14, 1968. pp. 55-58.

    During 1968 a division of continuing education in the health sciences was established at the University of British Columbia. Representatives of 11 health sciences on campus began to organize and work together as a continuing education leader group. This group included a representative each from dentistry, hospital administration, library science, medicine, nursing, nutrition and dietetics, occupational therapy, pharmacy, physiotherapy, and social work, and a member responsible for developing the concept of interprofessional undergraduate education in the UBC Health Sciences Centre. The author proposes for the group's benefit the following definition of *health sciences team:* "A group of health professionals with their respective associated technologists, technicians, and other essential personnel, whose overall goals are the promotion of health, the prevention of disease, the diagnosis and treatment of illness, and the alleviation of suffering; who work cooperative and jointly to provide health and patient care embracing the sum total of relevant knowledge, skill and technology produced by all the sciences and applicable to other learned professions; and who recognize every healthy or apparently well person, each patient, and families and communities as integral participants in providing care." A glossary is furnished. (LY)

39. NEYLAN, Margaret Sarah and others. "An Interprofessional Approach to Continuing Education in the Health Sciences". *Journal of Continuing Education in Nursing.* July/Aug. 1971. Vol. 2, No. 4, pp. 21-28.

    Three key persons in the Health Sciences Centre at the University of British Columbia describe the development of an interprofessional approach to continuing education in the health sciences after three years. "The pattern of cooperative relationships in problem-solving activities is well established but constant maintenance is required. Shared leadership through rotating chair-

manship is presently a functional solution to administrative needs. Generally a climate of trust and optimism for the future has been created. Expansion of the membership of the Division to include other health sciences faculties and schools is under way. A secure foundation has been laid to permit the innovations needed to establish shared learning activities as an integral component of the rapidly growing field of continuing education in the health sciences." (RJB)

40. KILLIP, Devore E. "Dentistry". *Continuing Education for the Professions*, Edited by LeRoy Nattress, Natresources, Inc., Chicago, Ill. 1970. pp. 85-91.

Present-day continuing education for dentists is usually information designed to familiarize practitioners with the latest developments. It carries no credit and requires little involvement on the practitioner's part. Dental associations traditionally hire "big name" speakers for their courses. Universities offer participation-type courses. Because they have clinical or lab facilities, auxiliary staff, patients available, and an administrative apparatus to produce more and better programs, university dental schools bear the prime responsibility for responding to educational needs and directing the future growth of dental continuing education. The search goes on for new program models or revitalized older methods. Recent endeavors include community college training for volunteer practitioners (California) and home-study continuing education (Idaho). In addition, several states sponsor "circuit rider" programs using traveling teams of clinicians. (LY)

41. PODSHADLEY, Dale W. *Instructional Technology in Dentistry*. Academy for Educational Development, Inc., Washington, D.C. 1970. 22 p.

The author discusses the roles in dental education of instructional technology, specifically single-concept films, simulation, dial-and-random-access systems, television, programmed instruction and computers. He also discusses the continuing education of dentists, and looks at dental health in relation to the public. He summarizes that there is not enough dental health manpower to perform the important function of educating the public, and concludes that, if the job is to be done at all, it can only be with the assistance of available educational technology. (ERIC/GO)

42. BLOCKSTEIN, William L. "Myths and Realities–Continuing Pharmaceutical Education". *Journal of the American Pharmaceutical Association*. Jan. 1967. pp. 10-12.

The author discusses the inadequacies of the short, often incomplete seminars, and the inappropriateness of correspondence courses for pharmacists. He proposes that the solution lies in recognizing what information a pharmacist needs in order to keep current in his professional practice. He describes six objectives of a program of continuing pharmaceutical education which could be incorporated into a single program or be included in the overall design of a complete schedule of educational experiences to serve the needs of all pharmacists. (RJB)

43. KIRK, Kenneth W., and WEINSWIG, Melvin H. "Mandatory Continuing Education for the Relicensure of Pharmacists". *American Journal of Pharmaceutical Education*. Feb. 1972. pp. 48-55.

Only one out of twenty pharmacists participates in continuing education programs aroun. the country according to the authors. Kansas and Florida have mandatory continuing education requirements to maintain licensure and many other states are stuyding the issue. This article examines the current status of pharmacy continuing education (the type of offering, the obstacles to participation, the pharmacist's evaluation of programs); discusses the pros and cons of compulsory continuing education; and suggests ways of motivating practitioners to participate. The authors contend that mandatory continuing education is inconsistent with the professional ethics of a pharmacist and sees motivating pharmacists to become independent students as the ultimate goal of continuing education programs. (MAP)

44. MAJORS, Richard L. and BESTER, John F. "Continuing Education Programs by the Pharmacist". *Journal of the American Pharmaceutical Association.* Jan. 1967. pp. 23-24.

The authors ask, where are the continuing education programs *by* the pharmacist? They contend that the pharmacist's high qualifications to talk about drugs can do much to promote interprofessional relationships. He has much to contribute to educate associated professionals: dentists, optometrists, medical and dental office workers, podiatrists, nursing-home personnel, nurses and physicians. He can educate such health personnel in new drugs, new dosages, the effects of systematic medication, the legal responsibilities and liabilities in drug distribution, and legislative changes involving numbers and frequency of renewals for dangerous drugs. (MAP)

45. AMERICAN SOCIETY OF HOSPITAL PHARMACISTS. *Instruction and Procedure Manual on Institutional Pharmaceutical Service.* American Society of Hospital Pharmacists, Washington, D.C. 1972. 122 p.

In 1966, under a grant from the National Pharmaceutical Council, the American Society of Hospital Pharmacists established an on-the-job training program which orients the community pharmacist to practice in the institutional setting. This manual was written specifically for pharmacists interested in learning about institutional pharmacy practice. Although much of it deals with hospital pharmacy service, it may be applied to all institutional practice. Emphasis is on the small institution. The topics include: The Institutional Environment; Pharmacist's Administrative Responsibility; Drug Distribution and Control; Rational Drug Therapy; and Laws, Regulations, and Standards. (MAP)

46. MATZICK, Kenneth J. *A National Survey to Evaluate Continuing Education in the Field of Hospital Administration.* The Univ. of Iowa, Iowa City, Iowa. 1967. 91 p.

The author considered several ways in which new knowledge, techniques and information may be conveyed to the practicing administrator. He interviewed a large sample of administrators asking them whether formalized courses provide the most fruitful and effective mechanism. He asked also whether existing continuing education courses in the field of hospital administration are effective in transferring new knowledge to the practicing administrator. Only administrative assistants viewed continuing education courses as the most valuable mechanism. With minor deviations, all others considered personal interaction with other hospital administrators as most valuable,

hospital journals and periodicals next most valuable, and courses third. Sixty percent indicated that existing continuing education courses do not adequately accomplish the transfer of new knowledge. The author concluded "that a more formalized, comprehensive continuing education course is needed in the field of hospital administration, and that the American College of Hospital Administrators and one, several or all of the graduate programs in hospital administration should develop such an approach." The book contains information on eight kinds of formal programs. There are two pages of bibliographical references to books, articles and periodicals, and reports on continuing education for hospital administrators. (RJB)

47. UNIV. OF CHICAGO. Studies and Training Program in Continuing Education. *The Multi-Method Pattern for Short Courses.* Univ. of Chicago. Studies and Training Program in Continuing Education, Chicago, Ill. 1957. 6 p. Continuing Education Report, No. 14.

    Columbia University's Program of Continuing Education of the School of Public Health and Administrative Medicine has conducted short courses for administrators and middle management personnel of hospitals. The courses have combined individual home study and study in group situations. For nine years a twelve-month Basic Hospital Administration course was offered in which initial and final sessions of two weeks each were held at the University and the intervening eleven-month studying was done by correspondence between students and faculty and by individual guidance from a local experienced administrator called a preceptor. A second course, Management Development, similarly structured but for the middle management personnel, was offered three times with changes in such matters as curriculum content each time. The courses included home study, a preceptor arrangement, and an on-campus or conferenced portion. The very low dropout rates and the gratifying results give evidence for recommending such a three-dimensional approach to structuring job-related courses for adults wherever pos (ERIC/RT)

48. KOESTLER, Frances A., Editor. *Reference Handbook for Continuing Education in Occupational Therapy.* American Occupational Therapy Association, Inc., N.Y. 1970. 118 p.

    This handbook, prepared by a Task Force of the American Occupational Therapy Association, was designed primarily as a self-study instrument and organized around the modern educational concept of evaluating dysfunction in terms of established growth and development. Chapter topics are: Basic Knowledge Areas, Human Growth and Development, Evaluation, General Problems, Specific Symptoms and Problems, and Categories of Pathology. The final chapter suggests practical methods of self-assessment. The AOTA has prepared a companion volume, *Professional Reactivation in Occupational Therapy;* together they are major tools for encouraging inactive occupational therapists to return to practice. (MAP)

49. AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC. *Professional Reactivation in Occupational Therapy.* Kendall/Hunt Publishing Co., Dubuque, Iowa. 1969. 87 p.

    This was prepared by a Task Force of the American Occupational Therapy Association as guidelines for the non-practicing therapist returning to the

profession, the practicing therapist who guides the returner through refresher courses, and the prospective employer who hires the reactivated therapist. Topics include the professional therapist in the 70's, methods of facilitating reactivation, the adult as learner, planning refresher courses, and models for refresher programs. It should be used with a companion volume, *Reference Handbook for Continuing Education in Occupational Therapy.* (MAP)

50. MILLER, Leonard A., and others. *Studies in Continuing Education for Rehabilitation Counselors. Report No. 1: A Review of Context for Practice and Research; Report No. 2: Understanding the Work Milieu and the Personnel in Developing Continuing Education for Rehabilitation Counselors; Report No. 3: Rehabilitation Counselor Change Associated with Experimental Continuing Education Programs.* The Univ. of Iowa, Iowa City, Iowa. 1969-1971.

The objective of the Studies was to test experimentally the effectiveness of new voluntary approaches to continuing education for rehabilitation counselors using packaged learning materials easily available to the counselor. Report No. 1, *A Review of Context for Practice and Research,* 1969, 103 pages, reviews the influence of the work environment, the characteristics of the counselor and various aspects of teaching and learning; it also gives the background of the study and its design. Report No. 2, *Understanding the Work Milieu and the Personnel in Developing Continuing Education for Rehabilitation Counselors,* 1971, 102 pages, provides descriptive data on the counselors studied and the results from several of the data analyses carried out between 1969 and 1971. Report No. 3, *Rehabilitation Counselor Change Associated with Experimental Continuing Education Programs,* 1971, 77 pages, give outcomes from three different training approaches; in general, increases in counselor knowledge were successful but an attempt to measure improved interviewing skills was not. (RJB)

51. COMMITTEE ON CONTINUING EDUCATION. Medical Library Association. "Continuing Education of Medical Librarians". *Bulletin of the Medical Library Association.* July 1963. Vol. 51, No. 3, pp. 354-383.

This issue of the Bulletin carried four papers that were part of the first annual report of the Medical Library Association's Committee on Continuing Education. Together they report the groundwork thinking that was done by the committee appointed in 1962 to make basic studies, and to do thinking and planning. As the fundamental preparation, these papers are of lasting interest. The Committee, chaired by Estelle Brodman, wrote the introductory "Continuing Education of Medical Librarians," dealing with the purposes of continuing education and the sponsorship by the Medical Library Association. Harold Bloomquist and Margaret M. Kinney wrote the second, "Continuing Education in the Professions," which reviews architecture, the clergy, education, law, librarianship, medicine, and nursing. Betty A. Winthrow wrote "The Medical Library Association and Continuing Education," which includes lengthy bibliographical citations of historical episodes in continuing education for medical librarians. And Erich Meyerhoff wrote "Evaluation of the Association's Past Performance and Suggestions for the Future." The suggestions deal mainly with the need for experimentation, evaluation and high quality instruction. (RJB)

52. NATIONAL INSTITUTES OF HEALTH. Bureau of Health Manpower (DHEW). *Guidelines for Dietitians and Public Health Nutritionist in Home Health Services.* G.P.O., Washington, D.C. 1970 Revision. 20 p.

Prepared by the Public Health Service to clarify the role of health professionals and subprofessionals in the home-care field, this guide is directed to dietitians and public health nutritionists who are involved in planning, directing, carrying out, and evaluating the nutrition aspects of medical care programs for patients at home. Program descriptions and guidelines identifying the responsibilities and functions of dietitians and nutritionists are provided for (1) Home-Care Programs, (2) Homemaker-Home Health Aide Programs, and (3) Home Delivered Meals Programs. A bibliography on nutrition services in home health services is included. (ERIC/SB)

53. HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION. Division of Emergency Health Services (DHEW). *Training of Ambulance Personnel and Others Responsible for Emergency Care of the Sick and Injured at the Scene and During Transport.* G.P.O., Washington, D.C. 1970. 19p. Public Health Service Publication No. 1071-C-4.

Reports prepared by the National Academy of Sciences-National Research Council and the Task Force on Ambulance Services in April 1967 contended that the majority of ambulance personnel are inadequately trained, and that there are no generally accepted standards for the competence or training of ambulance attendants. The NAS-NCR's Committee on Emergency Health Services was asked by the Public Health Service to devise national guidelines, to make recommendations for specialized training for ambulance attendants, policemen, firemen, and rescue personnel, and to propose ways of developing a nationally acceptable training course for ambulance attendants. This document is a summary of those issues for persons who are seeking proficiency in emergency care and who set certification standards. (MAP)

54. CASE WESTERN RESERVE UNIV. Cleveland College. *Community, Creativity, Collaboration; A New Training Model in Mental Health.* Case Western Reserve Univ. Cleveland College, Cleveland, Ohio. 1970. 122 p. Summary report.

The training project was supported by the National Institute of Health and administered by Cleveland (Ohio) College of Case Western Reserve University. The goal was to produce organizational and community change by making mental health professionals aware of the challenge and potentials in the field of community mental health, and by creating a learning community in which people would be able to explore new concepts and ideas, confront their stereotypes, understand their resistances to change, and become more free and open with each other. An educational program, based on a human factors model, ran for two years; 94 mental health professionals, (social workers, psychiatrists, psychologists, nurses, etc.) representing 28 agencies, were trained. The program treated such topics as: community mental health concepts; new approaches to treatment–a systems approach; consultation process and methods; consultation and organizational change; and a problem-solving consultative model as a change strategy. Information obtained by research instruments administered during the program and by followup studies indicated that there had been a change in the perception of participants regarding the involvement of participating agencies with community mental health. (ERIC/PT)

1. CONTINUING EDUCATION FOR HEALTH MANPOWER

1.6 Self-Sponsorship of Programs

2. ADULT AND CONTINUING EDUCATION
3. PREPARATORY EDUCATION
4. HEALTH-CARE SERVICES

55. HUBBARD, John P. "Self-Education and Self-Assessment as a New Method for Continuing Medical Education". *Archives of Surgery.* Sept. 1971. pp. 422-424.

Hubbard contends that the developing trend to require participation in postgraduate courses in order to maintain membership in professional associations and societies often leads to a mere accumulation of "brownie points." The alternative recommended by the National Advisory Commission on Health Manpower is challenge examinations in the practitioner's specialty. Hubbard describes one type of self-assessment – the program of the American College of Surgeons known as the Surgical Education and Self-Assessment Program (SESAP). The practitioner enrolls for a self-administered set of multiple choice questions dealing with essential information for all surgeons. New information developed in the last decade is emphasized. The scoring indicated to the surgeon areas where he is deficient, and refers him to texts or authoritative articles. The program helps the surgeon discover his weak areas, in which remedial educational programs can be designed. Similar self-assessment programs have been devised by the American Psychiatric Association, the American Academy of Pediatrics, the American Society of Anesthesiologists, the American College of Obstetrics and Gynecology, and the American College of Podiatry. Hubbard predicts that self-assessment programs will multiply because they offer physicians an opportunity to prepare for recertification. (MAP)

56. AMERICAN MEDICAL ASSOCIATION. *Directory of Self-Assessment Programs for Physicians.* American Medical Association, Chicago, Ill. 1971. 49 p.

Of the 21 programs listed in this Directory, 19 are offered by specialty medical societies, one by the Philadelphia Medical Society and one by the University of Illinois College of Medicine. The form for each program is: Name, sponsor; brief description; format of assessment procedure; sample item (where available); length of time required to take exam; aids that may be used (if any); aids incorporated into the exam (if any); method of scoring, time required to get results, and information provided to the physician; cost to the participant; where and whom to write.

The Board of Trustees of the American Medical Association in November 1972 approved the establishment of a Self-Assessment Resource Center to provide means for evaluating self-assessment programs. The Center is a joint effort of the AMA's Division of Medical Education and the Center for Educational Development of the University of Illinois College of Medicine. On June 30, 1972, HSMA made a two-year grant for the project, which is being conducted by the University of Illinois Center for Educational Development. For information concerning the AMA Self-Assessment Resource Center, write Leo L. Leveridge, M.D., Department of Continuing Medical Education, AMA, 535 N. Dearborn St., Chicago, Ill. 60610. (RJB)

57. NATIONAL LEAGUE FOR NURSING. Department of Hospital Nursing. *Quest for Quality: A Self-Evaluation Guide to Patient Care.* National League for Nursing, N.Y 1966. 77 p.

This guide by the Committee on Quality of Patient Care of the National League for Nursing's Department of Hospital Nursing was prepared to help professional members of the health-care team evaluate the quality of patient care provided in short-term general or specialty hospitals. In has five sections: realization of illness, patient appraisal, planned care, execution of care, and restoration. As indices of health the guide uses physical, mental, psychosocial, spiritual, educational, vocational and financial, safety and legal aspects, thereby stressing the qualitative aspects of patient care. The guide is in the form of a chart listing indices and descriptions of practice. The evaluator then fills in the factors which prevent or allow action, and makes comments on the practice; this points up "why" and "how" each factor enters into a nursing-care situation. (MAP)

58. ADAMS, Shirley. "A Self-Study Tool for Independent Learning in Nursing". *Journal of Continuing Education in Nursing.* May/June 1971. pp. 27-31.

Adams identifies some of the obstacles to independent learning in nursing and then describes the Wisconsin Inactive Nurses Studies (WINS), a series of independent study guides designed by Signe Skott Cooper, Chairman of the Department of Nursing, Health Sciences Unit, University Extension, University of Wisconsin, for inactive nurses. Under a Wisconsin Regional Medical Program grant, Cooper set up an Educational Telephone Network and refresher courses in small communities. Adams describes the development of self-contained study units on more than 30 topics available inexpensively to practitioners and inservice educators from the Department of Nursing, University of Wisconsin Extension. (MAP)

59. PIGORS, Paul and others. *Professional Nursing Practice; Cases and Issues.* McGraw-Hill Book Co., N.Y. 1967. 549 p.

Designed chiefly to promote independent study in administrative and other forms of decision-making through a modified case method, this book on continuing education in nursing presents the organizational setting and key personnel at a New England hospital; ten episodic cases, with key facts and questions, derived from a three year study done within the hospital; general guidelines for making the most of the incident process through group dynamics (especially role playing and conference discussions); and a brief teaching guide containing discussion plans for the case studies. In particular, Chapter 5 ("Leading Roles for Conferees") covers the general responsibilities of a discussion leader and a participant observer reporter. Job descriptions, case abstracts, and other appendixes are also included. (ERIC/LY)

60. SELF-INSTRUCTIONAL MATERIALS PROJECT. *Newsletter and Directory of Materials.* Self-Instructional Materials Project: Southern Medical School Consortium.

Medical schools within the Southern Region of the American Association of Medical Colleges in 1971 began the Self-Instructional Materials Project. Its aims include: (1) the training of faculty for production of self-instructional

materials, (2) the try-out of materials among schools, with subsequent revision, and (3) the sharing and dissemination of materials among consortium members. The activities of the project are workshops, a "package bank," reproduction and validation of materials, and a directory of materials and a newsletter. The conferences are producing a growing cadre of medical educators who are workshop trainers. As of the beginning of 1973, 32 medical schools were members of the project, each with a coordinator. The editor is Rita B. Johnson, Ed.D. The editorial office is School of Medicine, University of North Carolina, Chapel Hill, N.C. 27514. (RJB)

1. CONTINUING EDUCATION FOR HEALTH MANPOWER

1.7 Professional Association Sponsorship of Programs

2. ADULT AND CONTINUING EDUCATION
3. PREPARATORY EDUCATION
4. HEALTH-CARE SERVICES

61. THE AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS. *The Summary Report.* The American Society of Clinical Pathologists, Chicago, Ill.

This monthly subscription publication is a forum for the exchange of practical information and opinions concerning the medical laboratory and its problems. The *Report* is designed to provide an immediate evaluation of new techniques and instruments, a clearinghouse for the exchange of information and experiences, and a medium for questions and answers. It has about 2,000 subscribers, through whom, it is estimated, between 8,000 and 10,000 laboratory workers are reached.

This publication provides occasion to call the attention of non-clinical pathologists to what is probably the most comprehensive continuing education activities of any specialty society in the world. All of the ASCP educational programs are available not only to the 18,000 members of the Society, but also to all qualified laboratory personnel, physicians, clinical scientists and allied health personnel.

The continuing education activities are too varied and numerous to summarize in an annotation. Approximately 500 volunteer and staff members are required to maintain the day-to-day activities and special projects of the Society's Commission of Continuing Education. The Commission is supported by an administrative staff composed of a full-time Commissioner of Continuing Education, a Director and Deputy Director of Continuing Education Services, a team of Technical Project Managers, and other senior administrative personnel and specialists. In June 1971 the ASCP Educational Center was dedicated. It is a unique, privately financed facility for the development and conduct of a comprehensive program of continuing education service for all medical laboratory personnel. It provides year-round workshop opportunities to develop, utilize and distribute the latest educational tools of communication. It has an auditorium, specially constructed teaching and support laboratories, a library and resource center for individual study, a full-scale printing plant, an artists' studio and a television studio. All the educational programs of the ASCP Commission on Continuing Education are accredited by the AMA Council on Medical Education. The Society's

current educational activities can be classified in six categories–National and Regional Workshop Programs, Home Study Programs, Audiovisual Materials, Publications, Special Projects, and Research and Development Projects. For more information, write George F. Stevenson, M.D., Executive Vice President, American Society of Clinical Pathologists, 2100 West Harrison Street, Chicago, Ill. 60612. (RJB)

62. CALIFORNIA MEDICAL ASSOCIATION. *Guiding Principles for Continuing Medical Education in Community Hospitals.* California Medical Association. Committee on Continuing Medical Education, San Francisco, Cal. 8 p.

Medicine in California speaks with a single effective voice through the Scientific Board of the California Medical Association, which, since its establishment in 1962, has coordinated and strengthened the scientific and educational activities of CMA. The Scientific Board functions through 11 standing committees and 20 advisory panels. Two of the standing committees are Continuing Medical Education and Accreditation of Continuing Medical Education. In the past few years these committees have introduced bold, new approaches to continuing medical education, shifting from the traditional university-centered programs to learning experiences that take place primarily in community hospitals.

The Certification Program (for individual physicians) and the Accreditation of Continuing Medical Education Programs (for hospitals) are assisting practitioners and medical staffs in their systematic pursuit of effective educational objectives. Both the Certification and Accredition programs are voluntary, in contrast to programs in states such as Oregon, Arizona and Pennsylvania, where certification is required as a condition of renewal of membership in state medical societies.

For information or materials, write Committee on Accreditation of Continuing Medical Education, California Medical Association, 693 Sutter St., San Francisco, Cal. 94102. (RJB)

63. McCOMBS, Robert P. "Postgraduate Medical Institute: Its Challenging Role in the Continuing Education of Physicians and Other Health Care Personnel". *Massachusetts Physician.* June 1970. pp. 33-43.

This describes the Postgraduate Medical Institute, (PMI), a non-profit agency designed by the Committee on Medical Education of the Massachusetts Medical Society in 1953 to improve medical care through continuing education of physicians, nurses, and other health personnel. Some of its activities have included an educational television network, community hospital educational programs, development of a strategy of continuing education for all health personnel, medical self-evaluation examinations, development of community hospital libraries, and a program of advanced clinical education.

One of the PMI's productions since the article above was published was *Continuing Medical Education in Community Hospitals: A Manual for Program Development* (See Item No. 80). Indeed, the PMI activities are so many and dynamic that the reader is urged to write for more information, including the latest yearly reports, to Norman S. Stearns, M.D., Executive Director, Postgraduate Medical Institute, 30 The Fenway, Boston, Mass. 22215. (RJB)

64. STOREY, Patrick B. and others. *Continuing Medical Education: A New Emphasis.* American Medical Association. Division of Scientific Activities, Chicago, Ill. 1968. 128 p.

This records concepts and methods developed during the period 1963 to 1966 when the authors were engaged in developing the National Plan for Continuing Education sponsored by the American Medical Association; it attempts to resolve problems involved in implementing the plan. Two main lines of approach were used toward the objective of improving patient care through continuing medical education: (1) to develop a method for improving physician performance in a systematic way; and (2) to develop a means of involving physicians in such a program. The State of Utah was used for an inventory survey of physicians' needs.

A convenient overview of the wide-ranging and diversified activities of the AMA is in the annual report to the House of Delegates by the Executive Vice President. The latest and most comprehensive one, made by Ernest B. Howard, M.D., was published in *JAMA* Vol. 221, No. 5, July 31, 1972, two sections of which are below:

"Medical Education: The Council on Medical Education, its committees, and staff are an integral part of America's medical educational effort. Without the daily application of these enormous resources, the production of new physicians and their subsequent graduate and continuing education would experience a sharp setback. No aspect of the education and credentialing of physicians is untouched by the diverse activities of AMA's medical education arm.

"Among its noteworthy recent contributions are: (1) 41 surveys in the last year of existing, new and developing schools; (2) the 'Fifth Pathway Policy,' which provides supervised clinical training for U.S. students in foreign medical schools and subsequent entry into the midstream of U.S. medicine; (3) the annual education and licensure issues of *JAMA*, the authoritative references in these two important areas; (4) testimony on behalf of AMA for increased federal appropriations to support the growing medical educational establishment, and, coincidentally, a new awareness in academia of AMA's influence in stimulating legislative actions in their interests; (5) 80 surveys in the last 12 months for accreditation of continuing medical education programs; (6) the encouragement of parallel continuing education programs established in cooperation with AMA by more than 25 state medical associations; (7) the promotion of the California Medical Association's splendid accreditation program for continuing education in community hospitals as a prototype for other state societies; and (8) the first national Self-Assessment Resource Center to help guide and assist specialty societies with 'in-depth' self-assessment procedures."

"Education of Allied Health Professions and Services: Nineteen medical specialty and allied health associations cooperated with AMA in setting standards and approving educational programs for 18 allied health occupations. Noteworthy during the last year are the establishment of the Subcommittee on Proficiency and Equivalency Examinations to develop guidelines for such examinations, and surveys of nine programs for the training of assistants to primary-care physicians."

Reference is made above to the annual education issue of *JAMA*, a supplement in August, devoted to "Continuing Education Courses for Physicians." The 1972 supplement, dated August 14, was the 18th such annual listing. It included more than 2,000 courses of continuing education

for physicians in the United States offered by 578 institutions and organizations for the period from September 1, 1972, through August 31, 1973. The introductory pages have a section on "Relation of the Course List to the AMA Physician's Recognition Award": "Based on the previous three years' experience, new and revised criteria are being introduced with the 1972 award. The new criteria greatly broaden the kinds of continuing medical education activities that are creditable toward the award. They also recognize and give credit for many of the things that most physicians do to keep up to date."

C. H. William Ruhe, M.D., is Director of the AMA Division of Medical Education and also Director of the Department of Continuing Medical Education. Ralph C. Kuhli, M.P.H., is Director of the Department of Allied Medical Professions and Services.

The Division publishes two monthly newsletters: *Continuing Medical Education Newsletter,* edited by Lynn Thomas, and *Allied Medical Education* Newsletter, edited by Miss Susan Petrillo.

For all information about continuing medical education and continuing education in allied health field, or to be put on the mailing list for either or both newsletters, write C. H. William Ruhe, M.D., Director, Division of Medical Education, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610. (RJB)

65. BLOOM, Marvin L. "Origin, Development, and Implementation of New Continuing Education Programs". *Proceedings, National Conference of State Medical Association Representatives on Continuing Medical Education, Chicago, Ill.* Nov. 12-14, 1968. pp. 44-54.

There are three major forces in medical continuing education–the medical profession (AMA), medical schools, and Regional Medical Programs. Their respective roles urgently need to be defined to avoid fragmentation of effort. (Although pressures for compulsory program attendance are growing, Bloom thinks such compulsion would be motivationally unsound.) Federally authorized Regional Medical Programs (RMPs) have a mandate to facilitate continuing education and to integrate their own efforts with relevant educational, professional, and social agencies. There should be regional decentralization, with multiple community interfaces. Emphasis should be put on coherent organization and leadership; relevant programs with annually changing curricula based on clearly determined subject-area needs; appropriate delivery systems; and provisions for feedback and evaluation. The AMA would be the appropriate leader, implementing an intimate partnership with universities or medical schools in offering continuing education, and with the RMPs in assessing needs and evaluating performance. Universities would retain all essential academic prerogatives but share operational jurisdiction in continuing education. The AMA should also invite other regional, state, and national components to help design and join a new sector (possibly a health professions education council) which would guide operations of the total system. (LY)

66. DELP, Mahlon. "The Principles of Effective Continuing Education Programs". *Proceedings, National Conference of State Medical Association Representatives on Continuing Medical Education, Chicago, Ill.* Nov. 12-14, 1968. pp. 34-43.

Physicians' concern for continuing education suggests the presence of (and the continued need to preserve) their traditional sense of professional responsi-

bility for competence. Although the basic principles of medical continuing education are the same as those for undergraduate and graduate medical education, these principles may be poorly understood and executed in all three areas. Past efforts have been vitiated by inappropriate materials and experiences, needless and expensive duplication, narrow institutional objectives within medical education, and a lack of systematic planning. If it is broadly based and truly effective, continuing education will not lack participants. George E. Miller has said: "Continuing education should mean continuing self-education, not continuing instruction." An effective program by present standards requires administrative leadership, careful curriculum planning based on existing community and physician needs, suitable facilities and learning environments, a budget ample for present and future needs, competent teachers sympathetic toward the needs of their students, and willingness to encourage participative experiences. (Key concepts here are *environment and involvement.)* Appropriate evaluations based on objectives must be attempted. Finally a participant's reward should lie not in certificates but in personal satisfaction resulting from the ability to provide better patient care. (LY)

67. AMERICAN MEDICAL ASSOCIATION. *Proceedings, Second National Conference of State Medical Association Representatives on Continuing Medical Education, October 13-15, 1970.* American Medical Association, Chicago, Ill. Oct. 1970. 112 p.

The responsibility of organized medicine in the area of continuing education was the focus of this conference. Papers presented at the conference and summaries of workshop discussion groups compose this document. The papers are: Maintenance of Physician Competence; Motivation for Continuing Medical Education; Peer Review and Evaluation as Educational Tools; Regionalization and Continuing Medical Education; Continuing Medical Education–Issues and Answers; Developing and Teaching Faculty at Community Hospitals; Self-Assessment and the Professional Society; The Postgraduate Medical Institute Program in Continuing Medical Education; the MIST Program; Clinical Traineeships; and The Physical Profile Program for Continuing Medical Education. The workshops were on motivation, evaluation, organization and methods, financing, and the role of the State medical association in continuing medical education. (ERIC/DB)

68. PETIT, Donald W. "The Physican Recognition Award". *Journal of the American Medical Association.* Sept. 7, 1970. pp. 1568-1569.

Petit reports establishment in 1970 by the American Medical Association of the Physician Recognition Award, a voluntary recognition award for physician participation in continuing education. The requirements are 150 credit hours of continuing education in a period of three years, 60 hours or more made up of required education activities, the remainder of elective education activities. (The required activities are accredited continuing education courses, papers or publications, and teaching. Elective activities include attendance at the scientific meetings of other national professional societies, local or regional scientific meetings, presentation of scientific exhibits, and additional teaching exercises.) Petit calls for a review of the purposes of continuing medical education. He notes that the establishment of a reward is a simple thing but

the secondary effects on accreditation, on educational fare, on evaluation, will be great. He says that the traditional courses, symposiums, and retreats must be supplemental with small-group learning, in-hospital training, greater medical school involvement, and the utilization of newer techniques to determine educational needs. (MAP)

69. JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. Editorial: "Continuing Medical Education: Does It Matter?" *Journal of the American Medical Association.* Aug. 6, 1966. p. 505.

This editorial reports that the 12th annual *JAMA* listing of all AMA accredited courses for continuing medical education courses for 1966 included over 400 institutions, presenting more than 1,600 courses. Combined registrations for the previous year were put at 150,000 physicians. The editorial asks, how can it be shown that there is a relation between the courses and improved medical care? It suggests that the measurement of activity is a weak indicator. A stronger approach would be to demonstrate the effect of educational programs on the attitudes and practices of physicians. *JAMA* sees a need for better ways of assessing results. (MAP)

70. SPECTOR, Audrey F. "The American Nurses' Association and Continuing Education". *The Journal of Continuing Education in Nursing.* March-April 1971. pp. 41-45.

The author, Coordinator of Continuing Education for the ANA, outlines the organization's efforts to develop continuing education programs and to determine standards for education and practice. Emphasis is on practice and the ANA makes use of clinical programs at biennial conventions, the presentation of clinical papers, an increased number of clinical sessions, nursing problem clinics, and regional clinical conferences. Spector comments upon the ANA's stand on inservice education as an avenue of continuing education, its role in promoting nursing education legislation, its relationship to other groups, and its current plans for preparing nurses for expanded roles. (MAP)

1. CONTINUING EDUCATION FOR HEALTH MANPOWER

1.8 Educational Institutions Sponsorship of Programs

2. ADULT AND CONTINUING EDUCATION
3. PREPARATORY EDUCATION
4. HEALTH-CARE SERVICES

71. NATIONAL INSTITUTES OF HEALTH. BUREAU OF HEALTH MANPOWER EDUCATION (DHEW). *Allied Health Education Programs in Junior Colleges 1970.* G.P.O., Washington, D.C. 1972. 402 p. DHEW Publication No. (NIH) 72-163.

This directory of allied health programs in community junior colleges was compiled by the American Association of Junior Colleges for the Division of Allied Health Manpower under Contract No. NIH 70-4125. Data was collected

by spot surveys or surveys that were selective by geographic area or health specialties. Thus it is not comprehensive. (RJB)

72. AMERICAN ASSOCIATION OF JUNIOR COLLEGES. *Extending Campus Resources: Guide to Using and Selecting Clinical Facilities for Health Technology Programs.* The American Association of Junior Colleges, Washington, D.C. 1968. 28 p.

    The guide was designed for community junior colleges to help them pick and use the available clinical facilities that fit their curricula. It is useful also to hospitals seeking relationships with colleges to help them in their educational programs for allied-health manpower. (RJB)

73. AMERICAN ASSOCIATION OF JUNIOR COLLEGES. *A Guide for Health Technology Program Planning.* The American Association of Junior Colleges, Washington, D.C. 1967.

    This gives principles to guide collaboration among junior colleges, community health facilities and associations of health practitioners in planning joint academic-clinical programs. (RJB)

74. KINSINGER, Robert E. *Education for Health Technicians–An Overview.* American Association of Junior Colleges, Washington, D.C. 1965. 35 p.

    This is a report based on a national study conducted under the auspices of the AAJC, funded by the Alfred P. Sloan Foundation. The author, director of the Community College Health Careers Project, the University of the State of New York, concludes: "We find our society faced with a growing and shifting need for technicians and assistants in the health field. Hospitals are turning over some of their educational activities to two- and four-year colleges. Community colleges have already demonstrated their ability to successfully prepare health technicians in selected fields. Some well conceived pilot programs give promise of a willingness on the part of the colleges to expand their activities. New education programs to meet the needs must be regionally developed by study groups of health professionals, technicians and educators. The colleges must establish relationships with health agencies for use of clinical facilities. Most important of all, a corps of outstanding technicians must be identified, recruited, and prepared as teachers. . ." (RJB)

75. KIMBROUGH, L.S. *Physicians in Residence Program. Final Report, Supplemental Report, and Conference.* California Univ. Medical Center, San Francisco, Cal. 1969. 355 p.

    The Physicians-in-Residence (PIR) Program was developed for 14 hospitals in Northern and Central California communities and in Reno, Nevada, to establish continuing education programs for practicing physicians in local communities. The hospitals were selected, the most urgent needs of the medical staff of each hospital were identified, and members of the medical faculty from the University of California were selected to teach at 3-day meetings at each of the hospitals. Following the visit, each PIR made a detailed report to the project director. At the end of the program, a conference between the Continuing Education Staff, participating faculty,

and representatives of the community hospitals was held to discuss the impact and effectiveness of the educational program. The local hospitals were unanimous in their desire to maintain and extend the program. In some instances, patient care had improved, and new facilities not previously contemplated had been planned. The medical school faculty indicated that their experience in the community hospitals might modify their approach to medical students. (ERIC/BC)

76. ROBERTSON, William O. and DOHNER, Charles W. *Study of Continuing Medical Education for the Purpose of Establishing a Demonstration Center for Continuing Education in the Pacific Northwest. Final Report.* Washington Univ. School of Medicine, Seattle, Wash. 1970. 324 p.

This study was conceived to (1) define the educational needs of medical practitioners in the Pacific Northwest, (2) assess the resources available to meet these needs, (3) determine what educational programs are needed, (4) develop evaluation methods for these programs, (5) identify physician participation factors, (6) develop evaluation techniques for clinical communication systems, (7) evaluate recent continuing education programs, and (8) develop a comprehensive plan for a continuing education center. The report describes in detail the techniques used to accomplish these objectives, with questionnaires and survey results contained in the appendixes. Ideally medical education should continue in a lifelong pattern developed during undergraduate study. With improvements in program content, promotional efforts, information networks, and program offerings in individual hospitals, continuing education can be made an integral part of physicians' careers. (ERIC/BH)

77. COOPER, Signe S. "The Contribution of the University to the Continuing Education of Nurses". *International Journal of Nursing Studies.* 1968. pp. 273-279.

This article briefly describes the history and current programs offered in continuing professional education through the University of Wisconsin Extension Division Department of Nursing. (ERIC/DM)

78. AMERICAN PUBLIC HEALTH ASSOCIATION, Inc. *Course Listing 1971-1972. Program for Continuing Education in Public Health.* American Public Health Association, Inc. Western Regional Office, San Francisco, Cal. 1971. 14 p.

Courses to be presented in 12 states for the benefit of professional personnel in health and related fields are listed and briefly described. The courses were developed by the Program of Continuing Education in Public Health, with the aid of Graduate Schools of Public Health of the University of California at Berkeley and at Los Angeles, the University of Hawaii, and Loma Linda University; the program is also sponsored by the Western Branch/Western Regional Office of the American Public Health Association. The courses are on Administration, Environmental Health, Mental Health, Personal Health Services, Teaching Health Planning, and The Extended Role of Public Health Workers. A list of persons to contact by persons interested is given by state: Alaska, Arizona, California (both Northern and Southern), Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming. (ERIC/DB)

1. CONTINUING EDUCATION FOR HEALTH MANPOWER

1.9 Health-Care Institutions Sponsorship of Programs

2. ADULT AND CONTINUING EDUCATION
3. PREPARATORY EDUCATION
4. HEALTH-CARE SERVICES

79. HOSPITAL RESEARCH AND EDUCATIONAL TRUST. *Training and Continuing Education: A Handbook for Health Care Institutions.* Hospital Research and Educational Trust, Chicago, Ill. 1970. 261 p.

This basic handbook for personnel development through training and continuing education within health care institutions describes the techniques involved in developing programs, from needs determination to evaluation. It covers how to make a skill inventory and a survey of learning needs; how to state learning objectives; how to design a specific supervisory development program in a representative hospital situation; how to prepare the instructor's guide (with a detailed plan for program session); how to use teaching tools, such as puzzles, rating scales, and games; how to use the case study, role play, and in-basket exercise; and how to produce and use various types of audiovisual media. There is discussion of both entrance and exit interviews and handling disciplinary situations. A special section is included on the training of nurses' aides, and the work of food service personnel, ward clerks, and housekeepers is analyzed. Numerous illustrations, checklists, exercises, and case studies are included. Most chapters have lists of readings, and there is a bibliography and an index.

This publication gives occasion to call attention to the wealth of authoritative, low or reasonable cost materials available from the American Hospital Association, which can be surveyed by getting the latest "Order Form for AHA Publications," available upon request from AHA, 840 N. Lake Shore Dr., Chicago 60611. Virtually all aspects both of health manpower continuing education and training (except medical education) and all related factors are included. For example, the "Order Form" has sections on "auxiliaries and volunteer service," "careers," "health care delivery," "library service," "medical records," "nursing," "personnel administration," "planning," and "prepayment and utilization." The section on "education and training" include more than 25 items, including the valuable publications of the Hospital Research and Education Trust. Among these latter are *Correspondence Education and the Hospital; Programmed Instruction and the Hospital;* and four sets of "basic training programs for food service workers, housekeeping aides, nursing aides, and ward clerks (See Items No. 91, 92, 93 and 94.) Now that the American Society for Hospital Education and Training, an affiliate of the AHA, has been established (in 1971), additional materials are being produced. (RJB)

80. STEARNS, Norman S., GETCHELL, Marjorie E. and GOLD, Robert R. *Continuing Medical Education in Community Hospitals: A Manual for Program Development.* The Massachusetts Medical Society, Boston, Mass. 1971 179 p.

The manual describes the need for continuing education and suggests the community hospital as one of the best settings. It outlines a "Systematic

Approach to Developing Education Programs," which chapter by chapter describes eight basic steps that must be taken in the hospital: (1) Obtain support for the program; (2) formulate the goals; (3) identify the educational needs of the staff; (4) set objectives for meeting the need of the staff; (5) explore the methods of teaching; (6) determine the needed personnel; (7) present the educational program; and (8) evaluate the effect the program has on meeting objectives. Each chapter has a bibliography. The problem of relating continuing medical education to quality-of-care assessment is addressed in the manual by guest contributors, including Angelo Angelides, M.D., and Clement Brown, Jr., M.D. For the medical educator or others involved in fostering the development of continuing education programs at community hospitals, the manual also contains chapters on delivering education consultation to community hospitals. (See Item No. 63.) (MAP)

81. FREYMANN, John Gordon. "The Community Hospital as a Major Focus for Continuing Medical Education". *Journal of the American Medical Association.* Oct. 14, 1968. pp. 615-616.

The author sees the university hospital, the medical school and the community hospital as all necessary for continuing medical education–their relationship being "symbiotic," to extend in time from preprofessional education to life-long learning, and in space from the university research center to the "furthermost local medical doctor" ". . .the boondocks exist only in the eye of the viewer. The boondocks are where the other fellows work. Where I work is 'the field.' " The community hospital should be one of the foci of continuing medical education. "It is time to abolish academic condescension toward the community hospital and defensiveness by the community hospital." (RJB)

82. EVANS, Robert L. "The Pyramid of Care and Education Within the Hospital". *Association for Hospital Medical Education Journal.* Aug.-Sept. 1970. Vol. 3, No. 6.

The author, vice president, Medical Affairs, York Hospital, York, Pa., deals with the "redefinition of the educational role of the hospital" in the light of legal decisions making "mandatory the involvement of hospital staff, trustees, and administrations in the evaluation of patient care and in continuing education." He contends that "the evaluation of patient care and education in our institutions are not just similar, or interrelated, or interwoven–*they are the same.*" He presents a diagram of a "pyramid of care and education within the hospital" with four layers. The base is "continuing education and quality of care." The next layer above is "graduate education". The third layer up is "undergraduate education." The peak is "research." "Every level of the pyramid is based on what has been done at a lower level and is strengthened by feedback from the higher levels." The most important feature, he says, is the base of continuing education. The hospital functioning with such a pyramid is a "totally competent educational institution, with the intellectual stimulus to produce a regenerative cycle of physician motivation. The medical staff that does not embody these concepts in daily operation has no moral or ethical right to exist." (RJB)

83. KASABA, Rosalie and ABATO, Becky. *Scientific Design of a Hospital Training System.* Health Services and Mental Health Administration. National Center for Health Services Research and Development (DHEW), Rockville, Md. 1971. 165 p.

This is the report of a study conducted by the Research Staff, Holy Cross Hospital, San Fernando, California, from September 1967 – March 1970. The general hospital was the first on the West Coast to be designed and constructed according to an architectural concept emphasizing patient-centered care. The basic idea is to separate the flows of clean and soiled items and to provide that all needed supplies be at the point of patient care, thus saving nurses' time. The Holy Cross administration, realizing that traditional methods of training personnel in support positions were inadequate to meet the demands of this hospital design, developed a modular approach to training. The study is based on a definition of the total hospital functional structure and identification of its work components. It provides performance standards, methods for measuring performance, and training programs. (MAP)

84. CONGRESS OF THE U.S. HOUSE COMMITTEE ON VETERANS' AFFAIRS. *Training of Health Service Personnel in the Veterans' Administration.* G.P.O., Washington, D.C. 1971. 123 p.

During the fiscal year 1970, more than 49,000 persons received training through the Veterans' Administration (VA) in 125 different health services programs, including 21,550 physicians, 1,359 dentists, and 26,142 trainees in the allied and administrative health fields. Many VA hospitals and out-patient clinics indicated that more than 12,000 additional trainees could be accommodated by September 1971 if funds were provided immediately for trainee stipends, instructor salaries, space modification, and other pertinent costs. This publication lists the VA hospitals and outpatient clinics alphabetically for each of the 50 states, Washington, D.C., Puerto Rico, and the Phillippines, and provides for each VA hospital and outpatient clinic, data concerning the health services training program accomplishments in fiscal year 1970 and the potential expansion by September 1971. (ERIC/SB)

85. DOLLINGER, Malin R. and others. "A Novel Program of Continuing Medical Education". *Journal of the American Medical Association.* May 1, 1972. pp. 714-716.

This describes a continuing education program for 13 fields of internal medicine begun in 1969 by Harbor General Hospital (Torrance, California) and California Regional Medical Programs, Area IV. One participating physician is assigned as a "trainee" to each clinic where he spends one half-day a week for two months working under the direct supervision of full-time staff physicians seeing patients from a cross-section of the community. Thus, contend the authors, the learning experience is patient-oriented; the educational emphasis is placed on the individual's needs; there is no loss of physician income; and the information offered is reinforced by repetition, direct applicability to practice, and questioning. Out of 2,319 continuing medical education courses offered in 611 institutions from 1970-1971, only 68, say the authors, combine two of the important features of this program: The training does not interfere with the physician's private practice, and "live" clinics are the educational method. (MAP)

86. ARNDAL, Otto and others. "You and Your Hospital: How the Hospital's Staff Can Be of Greatest Help." *Patient Care.* Jan. 15, 1972. pp. 40-51.

Participants at this round table discussion represented large and small hospitals, private attendants and full-time hospital staff, administrative and medical staffs, as well as the Joint Commission on Accreditation of Hospitals. Some major points include: The role of the Director of Medical Education is evolving from recruiter of house staff to chief of education for attending staff; doctors with lax attitudes toward continuing education should be notified that their cases will be discussed anonymously at staff meetings; the nurse must be considered as more than just a "handmaiden"–she must be part of the team; the nursing shortage may be the result, not of too few nurses, but of poor organization; patient-care committees made up of those who provide direct service to patients should be created to make problem-solving recommendations. (MAP)

87. McBRIDE, Donald E. and KENNEDY, Rose Lee. "Patient Care Conferences: An Interdisciplinary Approach to In-House Continuing Education". *Journal of Continuing Education in Nursing.* Jan./Feb. 1972. pp. 22-24.

The Patient Care Conference at Grandview Hospital (Dayton, Ohio) is a working model of one means of continuing education within a hospital. Involvement of nurses, physicians and allied-health professionals from every department within the hospital is a unique feature of the Conference, and promotes an awareness of each others' capabilities among the staff which leads ultimately to a better understanding and treatment of the patients. (ERIC/Author/EB)

88. ROBBINS, A. and WHITE, W.D. "Role of the On-The-Job Training in a Clinical Laboratory". *Monthly Labor Review:* March 1971. pp. 65-69.

Employment conditions in the health industry are characterized, in general, by low wages, poor promotion opportunities, and inadequate on-the-job training. Below the supervisory level, labor turnover is a major problem. Promotion ladders in the laboratory are rare for unskilled workers; the main promotion ladder is for college students working as part-time night technicians who, after completion of laboratory training, become technicians employed on part-time work. Recently the gap between laboratory wages and industrial wages has been closing but the average wage for technicians is still below that paid in industry. On-the-job training plays a key role; the principal method of training is teaming. About 30 percent of all technician time is spent in training-related activities, either as trainees or as the experienced member of the team; each team does the work of one technician, so that 50 percent of the time spent is unproductive. The maximum amount of training received by a technician is equivalent to a period of six months spread over three years; the training fits in with the work schedule of the laboratory. Direct costs of training are low; low costs help to minimize costs of turnover, but low pay increases the turnover. Developments in the health industry are likely to break this circle: rising wages, training transferred to educational institutions, and automated laboratory processes which call for changes in skill requirements. (ERIC)

89. AMERICAN MANAGEMENT ASSOCIATION. *How to Train On The Job: A Programmed Instruction Course for Hospital Supervisors.* American Management Association, N.Y. 1969. 123 p.

The third in a special series, this programmed course is designed to teach hospital supervisors how to train subordinates on the job. It explains the nature and use of practice frames while guiding users through the following content areas: advance planning for on-the-job training; preparing trainees for a training session; explaining the task or job; following up. A sample training schedule is presented. Finally, a brief manual for training directors covers course preparation and validation, course administration, and testing. (ERIC/LY)

90. FIESTER, Kenneth. "Upgrading Hospital Workers". *Manpower.* Aug. 1970. pp. 24-27.

Under the sponsorship of the American Federation of State, County and Municipal Employees (AFSCME), a training program for upgrading hospital workers has been developed and used in the Boston area, and in Ohio and Maryland. The program's intent is to take workers who have been in low-level hospital jobs for a number of years and upgrade them so that they are qualified to hold higher-level (and better paid) jobs–nursing assistants, dietitian assistants, etc. The union prefers this approach of upgrading (and therefore providing more new openings at the bottom of the career ladder) to "leapfrogging" new recruits into better paid positions and leaving long-term employees in the same menial jobs. Selections for training are based on seniority and previous job performance. The AFSCME has felt the upgrading program to be so successful that they may consider its application in other than the hospital-health field. (ERIC/MP)

91. HOSPITAL RESEARCH AND EDUCATIONAL TRUST. *Training the Ward Clerk.*
92. *Training the Food Service Worker.*
93. *Training the Nursing Aide.*
94. *Training the Housekeeping Aide.* Hospital Research and Educational Trust, Chicago, Ill.

Produced by the HRET–an affiliate of the American Hospital Association–are these four "total teaching packages": student manuals, instructor's guides, and supplementary visual aids for use in classrooms or on-the-job training. In each package, the student manual and the instructor's guide function together as a complete program; the visual aids are designed either to supplement the textbook presentation or to be used alone. Information and order forms may be obtained from the HRET, 840 North Lake Shore Drive, Chicago, Ill. 60611. (See second paragraph of Item No. 79.) (RJB)

95. BROWN, Philip S. *Manual on Volunteer Services in Homes for the Aging and Nursing Homes.* Texas Association of Homes for the Aging, Austin, Tex. 1970. 31 p.

Intended as a practical guide for the administrator in homes for the aging, this booklet provides direction on how to set up a volunteer program. Five steps in organizing a volunteer program are: (1) Launching a volunteer program. (2)

recruitment and selection of volunteers, (3) orientation and training program (the role and function of a volunteer; philosophy, programs, and needs of the home; understanding emotional and medical problems of the elderly; tour of the facility), (4) placement, supervision, and inservice training, and (5) evaluation, promotion and recognition. The roles of the resident and director of volunteers, and volunteer opportunities are briefly described. A bibliography of resource materials is given, and samples of useful forms are reproduced. (ERIC/DB)

96. AMERICAN HOSPITAL ASSOCIATION. *Readings in Health Education.* American Hospital Association, Chicago, Ill. 1969. 173 p.

This collection of articles describes how various hospitals have planned, organized, and carried out educational programs for patients. It reviews more than 450 articles from 1950-1967. It both provides an overview of the status of patient-education programs in hospitals and identifies areas for further study and development. It is aimed at the hospital administrator and professional staff, giving them examples of patient, family and community health-education practices in a hospital setting. (MAP)

1 CONTINUING EDUCATION FOR HEALTH MANPOWER

1.10 Cooperative Sponsorship of Programs

2. ADULT AND CONTINUING EDUCATION
3. PREPARATORY EDUCATION
4. HEALTH-CARE SERVICES

97. DAINES, William M. "Cooperation Among State Medical Associations, Medical Schools, Voluntary Health Agencies, and Regional Medical Programs in Planning for Continuing Medical Education". *Proceedings, National Conference of State Medical Association Representatives on Continuing Medical Education, Chicago, Ill.* Nov. 12-14, 1968. pp. 24-33.

This report reviews events in the Intermountain Region (Utah and five surrounding states) which have influenced the course of continuing medical education, and it summarizes what has been learned. Major activities were threefold: two-way radio meetings and television broadcasts emanating from the Postgraduate Division of the University of Utah College of Medicine; and American Medical Association state survey of physician backgrounds, practice (group or solo), patient-care activities, and needs, problems, and methods used in continuing education; and a model Regional Medical Program begun during 1966-67, for the continuing education and training of physicians, nurses, and allied health personnel in cardiovascular diseases and cancer. Educational resources were interrelated in a way conducive to future planning and problem-solving. The Intermountain approach to structuring a program based on continuous self-education by physicians seemed logical. A physician's primary and major help must come from the organized medical staff of the community hospital; the college of medicine can extend and enlarge this resource. A RMP is an effective means of disseminating information and enhancing facilities outside colleges of medicine. Voluntary and specialty organizations offer in-depth programs of problem recognition and solution.

State medical societies can serve best by providing direction and by coordinating and evaluating resources. (LY)

98. ADULT EDUCATION RESEARCH CENTRE AND DIVISION OF CONTINUING EDUCATION IN THE HEALTH SCIENCES. *Proceedings of a Conference on Interprofessional Continuing Education in the Health Sciences.* University of British Columbia, Vancouver, B.C., Canada 1972. 89 p.

The Kellogg Invitational Conference on Interprofessional Continuing Education in the Health Sciences (ICEHS) was held at the University of British Columbia on June 4, 5, and 6, 1972. The purpose was to explore the nature, potential and operation of ICEHS with a group of leading continuing educators from several health sciences. Thirty-two continuing educators in dentistry, medicine, nursing and pharmacy attended, with 14 from the United States and 18 from Canada. Participants included ten each from medicine and nursing, eight from pharmacy, and four from dentistry. Six other continuing educators from the University of B.C. attended. These proceedings include background papers "Background to Interprofessional Continuing Education in the Health Sciences," by J.F. McCreary, and "Barriers to Shared Learning," by John R. Evans; work group reports and a dialogue with John R. Evans and Alan M. Thomas on "Barriers and Strategies in Interprofessional Continuing Education"; work group reports and a dialogue with Coolie Verner and Alan M. Thomas on "Conditions for Change and Planning Interprofessional Programs"; and a conference summation and evaluation. (See Items No. 10 and No. 36.) (RJB)

99. EVANS, Robert L. "Hospitals and Medical Programs: A Plea for Coordinated Action." *Hospitals.* Dec. 16, 1967.

Evans, director of medical education at York (Pa.) Hospital, discusses the state of American medical care which has been split by government funding into two separate systems–research and student education, and patient bed care. He explains the reasons for the communication gap, and makes recommendations for closing it through continuing education. While medical knowledge has been increased in the research centers, most health care has been delivered through the separate system of community hospitals. Communication between the two systems has become increasingly ineffective. Evans insists that the "only practical place to educate the practicing physician in a continuing and productive manner is in the milieu in which he works, and treats his patients, and earns his living–his hospital". (MAP)

100. WICHE Mountain States Regional Medical Program and Montana Medical Association. *A Symposium on Continuing Medical Education in Montana.* Western Interstate Commission for Higher Education, Boulder, Colo. 1969. 23 p.

The report of a symposium on continuing medical education in Montana, sponsored by the WICHE Mountain States Regional Medical Program, presents summaries of speeches of four consultants who discussed the following topics: How Can an Interprofessional Program Be Developed? Continuing Medical Education Problems, Priorities, and Plans; Can Health Professions Work and Learn Together? and Communication Problems Affecting Patient Care. Also included are general remarks on two general discussion sessions: "The Strategy of Interprofessional Continuing Education Development in Montana," and "The Development of a Plan for Continuing Medical

Education in Montana," which focused on a proposed research and education foundation authorized in March, 1968 by the Montana Medical Association. (ERIC/NL)

101. SCHECHTER, Daniel S. and O'FARRELL, Thomas M. *Universities, Colleges, and Hospitals: Partners in Continuing Education.* W. K. Kellogg Foundation, Battle Creek, Mich. 1971. 48 p.

In 1964-66, the Hospital Research and Educational Trust (HRET), an affiliate of the American Hospital Association, established seven regional centers for hospital continuing education in universities with graduate programs in hospital administration. The centers were a significant part of the Hospital Continuing Education Project (HCEP) under a grant from the W. K. Kellogg Foundation. This Kellogg publication is an elaboration of presentations given in 1968 at the annual meeting of the Association of University Programs in Hospital Administration and of reports prepared by the center coordinators at the University of Alabama, the University of California, Columbia University, Duke University, the University of Michigan, St. Louis University and the University of Minnesota. (JAHA)

102. HOSPITAL RESEARCH AND EDUCATIONAL TRUST. *Supervisory Training–The University, the Community College and the Hospital.* Hospital Research and Educational Trust, Chicago, Ill. 1971. 29 p.

This HRET publication is a description of the Minnesota activity in which the university collaborated with five community colleges in the upper midwest to offer supervisory training to hospital personnel. The report is presented in the hope that "it will suggest to universities, colleges, hospitals, and hospital associations in other regions how such agencies can work together." (JAHA)

103. LYSAUGHT, Jerome P. "From Abstract into Action". *Nursing Outlook.* March 1972. Vol. 20, No. 3, pp. 173-179.

This article, by the director of the National Commission for the Study of Nursing and Nursing Education, reports the immediate consequences of the shift of the National Commission from investigation to implementation following the publication of the report *An Abstract for Action*, in 1970. It reports first the administrative arrangements that brought about a National Advisory Council to supervise the implementation, supported by the W.K. Kellogg Foundation. Then it focuses on the follow-up on two of the major recommendations–for a national Joint Practice Commission, with state counterpart committees; and for statewide planning committees. First, the ANA Congress for Nursing Practice and the AMA Committee on Nursing were asked to help plan and organize the National Joint Practice Commission on the congruent roles of the physician and the nurse in providing quality health care. They gave such help in a memorandum of agreement which was approved by the boards of the two associations. A meeting inaugurating the National Joint Practice Commission was held in St. Louis, Mo., January 20-21, 1972. Second, on the recommendation that each state have, or create, a master planning committee that will take nursing education under its purview: In April 1971 the National Advisory Commission designated nine states for initial, intensive effort–California, Georgia, Illinois, Kansas, Maine, North Carolina, Pennsylvania, Texas and Wyoming. (See Item 25.) (RJB)

104. KRUSE, Lorane C. "A Nursing Coordinating Council for Continuing Education." *Journal of Continuing Education in Nursing.* Sept./Oct. 1971. pp. 47-49.

A coordinated council met to establish ground rules to coordinate the activities of various organizations and educational institutions interested in and concerned with the continuing education of nurses in Ohio. Their purpose was to provide all nurses with opportunities to increase their knowledge and skills for the delivery of health care. (ERIC/RB)

105. CURTIS, Frieda S., DARRAGH, Rita M. and others. *Continuing Education in Nursing.* Western Interstate Commission for Higher Education, Boulder, Colo. 1969. 108 p.

The authors (most of whom are directors of continuing edueation for nursing in state universities of the West) are members of the Continuation Education Seminar of the Western Council on Higher Education for Nursing (WCHEN), a council of the Western Interstate Commission for Higher Education (WICHE). The book is a guide for nurses who plan, conduct, and evaluate continuing edueation programs. It is the first nursing document based on the collective and individual experiences of a regional group of nurse educators working toward coordinating continuing education programs for a large geographical area. Chapter topics include organizational structure and function; curriculum development; human, physical, and material resources; financial resources and budget; and publicity and recruitment. Methodology and evaluation procedures are detailed by some of the same authors in a 1967 WICHE publieation, *The Effectiveness of a Leadership Program in Nursing.* (MAP)

106. CRAWFORD, Annie Laurie. *Teaching Psychiatric Nursing: A Report on Continuing Education for Faculty.* Southern Regional Education Board, Atlanta, Ga. 1970. 45 p.

A program sponsored by the Southern Regional Education Board (SREB) and financed by a grant from the National Institute of Mental Health sought to supply opportunities for continuing education in mental health and psychiatric nursing for the faculty of nursing schools in the southeastern United States. Thirty-five nursing instructors participated in a series of ten-day seminars held at six-month intervals. The seminar series covered such topics as group process, theory of community health, and theory of nursing education, as they relate specifically to psychiatric nursing. Virtually all participants were graduate nurses. (ERIC/MF)

107. OERTEL, Mary R. "Training Emergency Medical Technicians in New Mexico" *Health Services Reports.* March 1972. pp. 195-199.

A 1969 New Mexico Regional Medical Program survey of ambulance services showed that 85 percent of the state's ambulance personnel did not have current standard Red Cross first-aid training. To fill this gap, RMP's Emergency Medical Services Project, the University of New Mexico, and the Highway Traffic Safety Commission's Department of Transportation offered a 40-hour course in specialized medical training in emergency procedures and life-saving techniques. Long-range goals are the training of all emergency personnel in New Mexico to qualify as emergency medical technicians, and the offering of periodic refresher courses. (MAP)

108. GARTNER, Alan and JONES, Nina. *A Career Development Plan for Community Action Agencies.* New York Univ. New Careers Development Center, N.Y. 1968. 33 p.

A system for career advancement in the community action agency must be based on the principle that it should develop the full potential of the nonprofessional staff. Nonprofessional employees must be able to gain a variety of types of work experiences - e.g., the neighborhood worker must be able to work at supervision of other neighborhood workers, as a counselor in a Job Corps center, and as a coordinator of home health aides. The nonprofessionals should have easy mobility between component programs. The agency should seek out, or themselves plan for, opportunities for further education for nonprofessional employees, perhaps through use of a local community college or correspondence study. (ERIC/MF)

109. TIERNEY, John T. *Sickness and Poverty: A Handbook for Community Workers.* Health Services and Mental Health Administration. Public Health Service (DHEW), Washington, D.C. 1970. 89 p.

This expansion of *Chronic Disease - A Handbook for Public Welfare Workers,* was written as part of a comprehensive inservice training curriculum for public health welfare supervisors. This document emphasizes health problems affecting the poor. It is directed at community-service workers who deal with people who are both poor and ill. Forty-five health problems are listed (e.g., alcoholism, diabetes and veneral disease). The format is a description of each problem; its occurrence, cause, symptoms, treatment and prevention; and the implications for the community worker. (MAP)

110. LINDAMAN, Francis C. "Staff Training and the Working Relationships of Providers and Consumers in Spanish Harlem". *Journal of Public Health.* July 1970. pp. 1225-1229.

Seminars for professional and nonprofessional health workers in the East Harlem District of New York City were organized in an attempt to improve interpersonal relations among the workers themselves and between the workers and the community. The seminars demonstrated that: (1) relations with the community were strongly affected by interpersonal relations among the health district staff; and (2) very few white workers knew even the most elementary things about the life styles of blacks and Puerto Ricans, and black and Puerto Rican workers felt their white colleagues were incapable of understanding attitudes of nonwhites. This project has a number of implications for a large, metropolitan health department: (1) significant progress toward decentralization of health services is possible provided the workers are made to realize that the delivery of their services is vitally affected by teamwork with fellow workers; (2) decentralization of health care depends to a large degree on the individual health worker's commitment to the concept of total care; (3) it is erroneous to assume that people who have worked in the same office or center for years have even a basic understanding of one another's jobs; and (4) sensitivity training must accompany technical training if the worker is to be effective in today's complex and rapidly changing society. (ERIC/EB)

1. CONTINUING EDUCATION FOR HEALTH MANPOWER

1.11 Components of the Continuing Education Process
1.110 Overview

2. ADULT AND CONTINUING EDUCATION
3. PREPARATORY EDUCATION
4. HEALTH-CARE SERVICES

111. GAGNÉ, Robert M. *The Conditions of Learning*, Second Edition. Holt, Rinehart and Winston, Inc., New York, N.Y. 1970. 407 p.

The author identifies and analyzes eight types of learning: signal learning, stimulus-response learning, chaining, verbal association, discrimination learning, concept learning, rule learning, and problem-solving. He describes the conditions under which these types can be built into a hierarchy of learning, the more complex ones resting solidly upon the more basic; he describes how, conversely, in the teaching and learning of the more complex activities, one can deduce, or infer, the pre-conditions. The last chapter, "Resources for Learning," applies all this to communication in instruction, media for instruction, designing instruction using media, and modes of instruction. (RJB)

112. BROWN, Clement R. and UHL, Henry S.M. "Mandatory Continuing Education: Sense or Nonsense?" *Journal of the American Medical Association.* Sept. 7, 1970. pp. 1660-1668.

Brown and Uhl prefer practice-oriented continuing education to mandatory continuing education. They say that mandatory attendance at current "cure-all" programs of medical continuing education for unspecified ailments would frustrate the efforts of an increasing number of educators to create innovative approaches to education for practicing physicians. Largely because medical schools have seen undergraduate medical education as their primary obligation, the complex problems of continuing education did not receive thoughtful study until the 1960's. Technological and other effects of World War II led to the growth of specialization in courses and medical practice, which necessitated radical changes in the postgraduate educational structure. The traditional pattern of courses, conferences, and meetings lacked (and still lacks) a conceptual scheme that would link continuing education directly to identified physician and patient needs and permit objective evaluation of patient care. The "Bicycle" concept, developed by Brown and his colleagues at Chestnut Hill Hospital, Philadelphia, and the establishment of a consultative communications network with integrated educational components represent two promising approaches. In the first approach, the patient-care cycle begins with interaction with the physician, who determines the patient's problems and compiles a problem-oriented record. (Thus, continuing education should occur wherever a physician encounters a patient whose case represents a difficult problem.) The other approach would use closed-circuit television and other devices to involve doctors instantly in education related to patient care while saving time, effort, and resources. (LY)

113. McLAUGHLIN, Curtis P. and PENCHANSKY, Roy. "Diffusion of Innovation in Medicine: A Problem of Continuing Medical Education". *Journal of Medical Education.* May 1965. pp. 437-477.

The authors hypothesize that one measure of a physician's competence is his knowledge of recent research findings and his willingness to apply them to his own practice. To bridge the gap between research and application, medical schools and societies are devising many programs for the continuing education of physicians. These programs range from seminars and special courses to closed-circuit television. But the authors contend that before programs are planned important questions should be asked: What are the processes by which the practicing physician learns? Which of these are the most effective? Are different sources used for different medical problems? The examples given and the studies discussed in this article point up the high complexity of the diffusion of innovation among physicians. The authors suggests that the bits-and-pieces approach be done away with in favor of examining the whole system, which includes the source of information, the channel, the medical problem, the nature of the medical practice, the physician's background, his decision processes, the type of search in which he may engage, and the specific innovation. (MAP)

114. SCHWARTZ, Lawrence H. and SCHWARTZ, Jane Linkel. *The Psychodynamics of Patient Care.* Prentice-Hall, Inc., Englewood Cliffs, N.J. 1972. 422 p.

A goal of current health care is to "treat the patient, not the disease." To do so requires, in addition to compassion and competence, a knowledge of human psychology, specifically the psychology and behavior of people who are ill and more specifically the psychological-behavioral two-way relationship between people who are ill and those who give them care. This book is a resume of the dynamic psychology that underlies human behavior, divided by stages in the life cycle from birth until death, with each concept illustrated by case examples and each section followed by extensive references. Although the volume is specifically aimed at the nursing profession, it is equally appropriate to all others who are in direct contact with the patient. Its concern with the psychodynamics of the caretaker as well as the patient makes it particularly useful in the continuing education of professionals whose teaching and learning embrace changes in values and attitudes as well as improvements in skills and cognitive knowledge. (RJB)

115. GARTNER, Alan and RIESSMAN, Frank. *The Transformation of Training: New Kinds of Consumer Based Services Require New Kinds of Training–Based on Participatory Simulation.* New York Univ. New Careers Development Center, N.Y. 1971. 23 p.

If human services in American are to become more responsive to the needs of the consumer, the training of the service worker will have to be radically transformed. Currently, the training of human-service workers resembles prolonged apprenticeships. Teacher training, for example, requires general education and broad knowledge rather than specific skills that would make the service more productive. Changes in the character of human services require that these services be more consumer-oriented, that they be offered in the style of the consumer, and the consumer have the opportunity to

critically evaluate the service and, most important, that the consumer be as directly involved as the service giver. The training of human-service workers must prepare the worker for consumer participation. A training model is needed that is geared to the development of the specific skills required for effective service delivery. Participatory simulation can be applied to all kinds of training–that of teachers, social workers, doctors, and nurses. (ERIC/CK)

116. KORSCH, Barbara M. and NEGRETE, Vida Francis. "Doctor-Patient Communication". *Scientific American.* Aug. 1972. pp. 66-74.

The authors state that "the quality of medical care depends in the last analysis on the interaction of the patient and the doctor, and there is abundant evidence that in current practice this interaction all too often is disappointing to both parties." They attribute this poor communication to such factors as the use of highly technical language by the physician, the replacement of long-term relationships with a family doctor by short-term encounters with specialists, and the neglect by medical schools to teach the "art" of medical practice. The authors used the emergency clinic of the Childrens Hospital of Los Angeles as a setting for their selective examination of the doctor-patient communication process. This article gives background, describes the method used, and discusses the findings, including the correlation between patient satisfaction with the doctor's behavior in the visit and patient compliance with the doctor's instructions, the language barrier's effect on communication, and the failure by the physician to regard the patient's concern. (MAP)

117. NEGETE, Vida Francis, KORSCH, Barbara and MORRIS, Marie J. "Gaps in Doctor-Patient Communication". *New England Journal of Medicine.* March 6, 1969. Vol. 280, No. 10, pp. 535-540.

"Study of 800 outpatient visits to Childrens Hospital of Los Angeles to explore the effect of the verbal interaction between doctor and patient on patient satisfaction and follow-through on medical advice showed 24 percent of patients to be grossly dissatisfied, 38 percent moderately compliant and 11 percent noncompliant. The extent to which patients' expectations from the medical visit were left unmet, lack of warmth in the doctor-patient relationship, and failure to receive an explanation of diagnosis and cause of the child's illness were key factors in noncompliance. Complexity of the medical regimen and other practical obstacles also interfered with compliance. There was a significant relation between patient satisfaction and compliance. Also, illnesses that the mothers regarded as very serious were associated with increased compliance. There was no significant relation between the demographic variables tested and satisfaction or compliance." Another report of the same study is "Gaps in Doctor-Patient Communication," Barbara M. Korsch, Ethel Gazzi and Vida Francis Negete in *Pediatrics*, Nov. 1968, Vol. 43, No. 5. (RJB)

118. CORRIGAN, Robert E. and KAUFMAN, Roger. *Why System Engineering.* Fearon Publishers, Belmont, Cal. 1965. 71 p.

This book clearly explains what system engineering is, what it can be used for and how to use it. It should be useful to both managers of larger "systems"

and the educators who manage the "subsystem" of education and training. It should be an aid to the better use of education/training in a system and to the improved planning of education/training. (RJB)

119. MAGER, Robert F. and BEACH, Kenneth M., Jr. *Developing Vocational Instruction.* Fearon Publishers, Belmont, Cal. 1967. 83 p.

Robert Mager has a highly developed talent for explaining managerial and educational tasks clearly and simply. The book above lists, describes and analyzes the steps to be taken in a systematic development of a course in any vocational or technical area, and many academic areas. The steps are in a closed loop of three phases–preparation, development and improvement, and thus back to preparation again. In the preparation phase, the first step is to describe in general terms what someone does when performing the job (job description); the second step is to describe job performance in finer detail, listing each of the tasks and describing the steps in each (task analysis); the third step is to describe the student population as it exists; the fourth step is to prepare course prerequisites primarily on the basis of the student description; the fifth step is to prepare course objectives primarily from the task-analysis information; the sixth step is to adjust course prerequisites on the basis of the course objectives; the seventh step is to adjust course objectives on the basis of course prerequisites and also such administrative constraints as available time and facilities; the eighth step is to prepare instruments (examinations) with which to measure success–a prerequisite test for the students (entering skill test) and a criterion exam for the course (a final inspection and also the basis for later evaluation). In the development phase the steps are unit outlining, sequencing, content selection, procedures selection, sequence and lesson plan completion, and course tryout. The improvement phase is a cycle of three steps: a comparison of the performance of the students with the objectives of the course, a comparison of the objectives of the course with the job for which the course is preparatory, and revision and tryout, and hence back to the comparisons again. Chapter 14, "Sources of Instructional Materials," includes a four-page bibliography. It also has a chart-guide to information on specific procedures, materials and devices keyed by page numbers in four major books on instructional technology. (RJB)

120. NATIONAL INSTITUTE OF MENTAL HEALTH. DIVISION OF MANPOWER AND TRAINING PROGRAMS (DHEW). *Continuing Education: Agent of Change.* G.P.O., Washington, D.C. 1971. 192 p. Public Health Service Publication No. 2167.

"Continuing Education, Agent of Change" was the theme for the 1967 National Conference on Continuing Education in Mental Health sponsored by the Continuing Education Branch of the National Institute of Mental Health and held at the University of Chicago Center for Continuing Education. The conference emphasized the rapid social and technological changes which add urgency to the need for continuing education, and the creative planning and training techniques essential to the behavioral and organizational changes that must accompany technological change. Conference topics included: the involvement of the adult learner in the process of assessing needs, planning, conducting and evaluating continuing education programs; the educational and psychological needs of the individual; the planning and organizational

aspect of mental health continuing education programs; advances in educational technology; and suggestions for regional and national continuing education program organization in mental health. (MAP)

121. ALLEN, Richard G. "Application of Adult Education Methods to Hospital Training". *Adult Leadership.* May 1967. pp. 20-22; 40.

    As Director of Education and Training, Medical Service School, U.S. Air Force, Gunter Air Force Base, Alabama, Allen used a wide spectrum of students (new recruits and adult retrainees) to test and observe a variety of educational techniques. He doubts that "continual upgrading, inflating and generally overgrading" hospital jobs really improve the quantity and quality of technical skills needed. Gunter Medical Service School established a system of job analysis, outlines for training objectives, and a retraining program for instructors. Allen lists six guides for medical-care training programs: standard job description for all hospital jobs, nationally-accepted job-training standards for all hospital jobs, training programs based on standard objectives leading to agreed-upon terminal behavior, evaluation standards derived from the above, instructor personnel trained in utilized training methods derived from these procedures, and standardized inservice and formal training programs utilizing all of the above. (MAP)

79. HOSPITAL RESEARCH AND EDUCATIONAL TRUST. *Training and Continuing Education: A Handbook for Health Care Institutions.* Hospital Research and Educational Trust, Chicago, Ill. 1970. 261 p. See annotation at the numbered item.

80. STEARNS, Norman S., GETCHELL, Marjorie E. and GOLD, Robert R. *Continuing Medical Education in Community Hospitals: A Manual for Program Development.* The Massachusetts Medical Society, Boston, Mass. 1971. 179 p. See annotation at the numbered item.

122. U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE. *Training Methodology. Part I: Background Theory and Research.* 1969. 90 p.

123. *Training Methodology. Part II: Planning and Administration.* 1969. 119 p.

124. *Training Methodology. Part III: Instructional Methods and Techniques.* 1969. 100 p.

125. *Training Methodology. Part IV: Audiovisual Theory, Aids, and Equipment.* 1969. 80 p.

126. *Annotated Bibliography on Inservice Training for Key Professionals in Community Mental Health.* 1969. 52 p.

127. *Annotated Bibliography on Inservice Training for Allied Professions in Community Mental Health.* 1969. 43 p.

128. *Annotated Bibliography on Inservice Training in Mental Health for Staff in Residential Institutions.* 1969. 32 p. National Institute of Mental Health and National Communicable Disease Center, Health Services and Mental Health Administration, U.S. DHEW.

    The above seven bibliographies, published separately but in a series, were developed jointly by the National Institute of Mental Health and the National

Communicable Disease Center. They are available from the Continuing Education Branch of the Division of Manpower and Training or the U.S. Government Printing Office. (RJB)

1. CONTINUING EDUCATION FOR HEALTH MANPOWER

1.11 Components of the Continuing Education Process
1.111 Data Bases and Their Uses

2. ADULT AND CONTINUING EDUCATION
3. PREPARATORY EDUCATION
4. HEALTH-CARE SERVICES

129. COMMISSION ON PROFESSIONAL AND HOSPITAL ACTIVITIES *Professional Activities Study - Medical Audit Program (PAS-MAP)*

Increasingly performance records are being examined, both for the assurance of quality care and as the basis for the determination of educational need. A key step is the setting of standards - both optimal and minimal (beneath which performance is judged to be deficient). When the activity is conducted within hospital, the hospital's own records are used but there is still the question of comparison with national norms. The Professional Activities Study-Medical Audit Program (PAS-MAP) provided by the Commission on Professional and Hospital Activities, Ann Arbor, Michigan, is a national system supplying medical data.

The PAS-MAP System requires that charts of all patients who are discharged or who die be abstracted each month by participating hospitals. The abstraction process is determined by the PAS-MAP case abstract form. PAS-MAP then computerizes the hospital's data and returns it in various forms. The major mode of display is to arrange most of the approximately 40 administrative and 40 medical bits of data in vertical columns for each patient. Data on patients are arranged horizontally according to their diagnoses. Most of the 1,300 hospitals employing PAS-MAP (and thus contributing their charts to the data base) make considerable use of the administrative and utilization data they get back, and an increasing number of them are using the data for their quality assurance and continuing education activities.

For more information, write the Commission on Professional and Hospital Activities, 1968 Green Road, Ann Arbor, Mich. 48105. (RJB)

130. HURST, Willis and WALKER, H. Kenneth, Editors. *The Problem-Oriented System.* Medcom Press, N.Y. 1972. 287 p.

The problem-oriented patient record, as summarized by its originator, L. L. Weed, M.D., is comprised of: (1) the data base (including chief complaint, present illness, patient profile, review of systems, physical examination, and laboratory reports); (2) the complete problem list (a sheet in front of the chart with a numbered and titled list of every problem the patient has or has had. A problem is "anything that requires management or diagnostic work-up." The list is added to or changed.); (3) initial plans (each numbered and titled problem is followed by plans for getting more information for diagnosis and management, plans for therapy, and plans for educating the

patient and his family about each problem); (4) progress notes (each numbered and titled to correspond to the specific problem to which it refers).

J. Willis Hurst, M.D., says that the problem-oriented record has ten advantages: (1) It encourages the student, house officer and practicing physician to use sound logic in his thoughts about patients. (2) Its display system enables one to use the record as efficiently as one uses a dictionary. (3) It allows the physician to communicate his thoughts to nurses and others and thus be the director of the health-care team in the care of the patient. (4) It enhances the continuing education of the physician and all who assist him. (5) The logic system and display prepare the student and physician for the computer world. (6) The POR is a common bond between several doctors and a patient in group practices, which are increasing daily. (7) It makes possible more accurate clinical research and clinical investigation. (8) It gives order and substance to ward rounds, which become patient rounds, not lecture rounds. (9) It encourages a more meaningful way of talking about patients. (10) Patient care is improved by each of the preceding nine reasons.

The Department of Medicine of Emory University School of Medicine sponsored a national conference on September 10 and 11, 1971, titled "Teaching Methods and Patient Care with Emphasis on the Weed System." Seven hundred people attended, 300 representing 75 percent of the medical schools in the United States, Canada and Puerto Rico, the remainder representing the Veterans Administration, Air Force, Army, Navy, NASA, nurses, record librarians, computer experts and administrators. *The Problem-Oriented System* is based upon that symposium. Its 32 articles and the citations of literature pertaining to the problem-oriented system provide a bibliography of this innovation that is quickly permeating both patient care and health-manpower education, from preprofessional training through continuing education and training. The following is a list of some of the books and articles cited in this volume.

131. BJORN, J.C. "Physician's Assistant–Second Level Entrepreneur?" *Journal of Maine Medical Association* 62: 1971. pp. 133-134.

132. CROSS, H.D. "Educational Needs as Determined by the Problem-oriented Medical Record." *Journal of Maine Medical Association* 61: 1970. pp. 49-54.

133. GRAVES, S. "Better Record: First Step to Better Quality." *Modern Hospital.* April 1971.

134. HURST, J.W. "The Art and Science of Presenting a Patient's Problems." *Archives of Internal Medicine.* 128: 1971. pp. 463-465.

135. HURST, J.W. "How to Implement the Weed System." *Archives of Internal Medicine.* 128: 1971. pp. 456-462.

136. HURST, J.W. "The Problem-oriented Record and the Measurement of Excellence." *Archives of Internal Medicine.* 128: 1971. p. 818.

137. HURST, J.W. "Ten Reasons why Lawrence Weed is Right." *New England Journal of Medicine.* 284: 1971. pp. 51-52.

138. HURST, J.W. "What to Teach in Clinical Medicine." *Four Hats.* Year Book Medical Publishers. Chicago, Ill. 1970.

139. PUTSCH, R.W., III, Humphrey, John, and SCHUSTER, J.S. "Quality Care, Problem Orientation, and the Medical Audit." Published as part of the Seventh Annual Hospital Medical Staff Conference Proceedings held at Estes Park, Colo. September 1970.

140. SCHULTZ, Jan R., CANTRILL, Stephen V. and MORGAN, Keith G. "An Initial Operational and Problem-oriented Medical Record System for Storage, Manipulation, and Retrieval of Medical Data." *AFIPS-Conference Proceedings.* AFIPS Press. Montvale, N.J. 1971.

141. WEED, L.L. "CPC's as Educational Instruments." *New England Journal of Medicine.* 285: 1971. pp. 115-118.

142. WEED, L.L. "Licensure Through Performance." A special report of Dr. Lawrence L. Weed's paper, Missouri: Federation of State Medical Boards of United States, Inc. *Federation Bulletin* 57: (1) January 1970. p. 2.

143. WEED, L.L. *Medical Records, Medical Education, and Patient Care: The Problem-oriented Record as a Basic Tool.* Case Western Reserve University Press. Cleveland, Ohio. 1969. 273 p.

144. WEED, L.L. "Medical Records that Guide and Teach." *New England Journal of Medicine.* 278: 1968. pp. 593-599, 652-657.

145. WEED, L.L. and others. "The Problem Oriented Medical Record-Computer Aspects." (A supplement to *Medical Records, Medical Education and Patient Care).* Dempco Reproduction Service. Cleveland, Ohio. 1969.

146. WEED, L.L. "Questions and Objectives to the Problem-oriented Record." PROMIS Laboratory. Medical Center Hospital of Vermont, Burlington, Vt. n.d.

147. WEED, L.L. "Quality Control and the Medical Record." *Archives of Internal Medicine.* 127: January 1971.

148. WEED, L.L. "Technology is a Link Not a Barrier for Doctor and Patient." *Modern Hospital.* February 1970. pp. 80-83. (RJB)

149. BJORN, John C., and CROSS, Harold D. *Problem-Oriented Practice of Medicine: A System for Comprehensive Health Care.* Modern Hospital Press, McGraw-Hill Publications Co., Chicago, Ill. 1970. 146 p.

This is a book by physicians for physicians about the problem-oriented record as the basis for communication within a "well organized *system* of compassionate individuals who care for people. This system must be so constructed that the degree of availability of comprehensive health care for all the people can be assessed. The system must be constructed so that the physician need only select the role which he chooses to fulfill within its framework, always recognizing and facilitating the essential role of others besides himself." Bjorn and Cross explain how they use the "Weed system" in their small-community general practice "to effectively control the interfaces among the many physicians who are necessary to provide total care." Their book is a guide to other physicians in various situations to institute the

problem-oriented patient record. It has chapters addressed both to the preprofessional and to continuing education. Chapter VIII--"Chart Review: Patient and Physician Education"--develops the point that chart review in practice includes methods of assessing the needs of both physician and patient for continuing education. Twenty-four appendices in 49 pages include example of agreements, forms, records and case histories described in the text. (RJB)

150. SLEE, Vergil N. "The Future of the Medical Audit". Univ. of Colorado. School of Medicine, Boulder, Colo. 1970. Paper presented at the 7th Annual Hospital Medical Staff Conference, Estes Park, Colorado.

In this paper, Slee predicts that the internal medical audit is here to stay but he says it faces a serious threat from health consumers and legislative bodies that insist on "accountability" through external monitoring. The director of the Commission on Professional and Hospital Activities, differentiates between the medical audit and professional standards monitoring. The former is a system of continuing medical education that evaluates the quality of medical care as it can be seen in medical records. The latter is done by surveillance groups from outside and in no way provides anything toward the educational process. Slee mentions court decisions and legislation indicating that "accountability" to the public will prevail and that national standards of external auditing will be established. Throughout the paper, Slee calls upon the medical profession to maintain the internal medical audit as an educational function so that it is not lost in the development of the external audit for public accountability. (MAP)

151. EISELE, C. Wesley. "The Medical Audit in Continuing Education". *Journal of Medical Education.* April 1969. Vol. 44, pp. 263-265.

The author concludes, "The really effective continuing education of the practicing physician must be continuous, it must be based in the community hospital, and it must be directly related to the physician's day-to-day clinical activities. There is no educational tool that equals the internal medical audit in meeting these criteria. The episodic educational exposures provided by refresher courses and by the great variety of educational experiences brought into the hospital from the medical center are useful and highly desirable, but they are merely adjuncts and they are not effective substitutes. When outside programs replace the hospital's own patient-oriented programs, and this is often a great temptation, the medical staff's continuing education is incomplete and inadequate." (RJB)

152. ACHESON, H.W.K. "The Clinical Record as an Aid to Continuing Education in General Practice: A Medical Self-Audit". *British Journal of Medical Education.* 1972. Vol. 6, pp. 26-28.

The author, a professor in the Department of General Practice, University of Manchester, summarizes: "The design of an educational programme for an individual practitioner requires information about defects in knowledge, skills, and attitudes. In the absence of any machinery for the observation of a general practitioner at work it is suggested that the clinical record should be utilized as a means of self-audit." He describes physician decision-making as a problem-solving process of four parts: subjective data (obtaining information

from the patient), objective data (the record of physical examination and investigations), the assessment of the data that has been obtained, and the creation of a plan for the management of the problem. The procedure for self-audit that he spells out follows two works he cites--(1) Royal College of General Practitioners, "The Educational Needs of the Future General Practitioner," *Journal of the Royal College of General Practitioners*, Vol. 18, 1969, pp. 358-360; and (2) Weed, L.L. *Medical Records, Medical Education, and Patient Care*. Year Book Publishers, Chicago, 1970. (RJB)

153. PHANEUF, Maria C. *The Nursing Audit: Profile for Excellence*. Appleton-Century Crofts, N.Y. 1972. 113 p.

This is a guide for nursing administrators, supervisors, and staff to the nursing audit as a quality control measure. It suggests a systematic use of the patient-centered nursing audit to determine quality, and it presents examples of the development and use of the method in hospitals, nursing homes, and public health agencies. The appendices include directions for use in selecting valid samples of patient-care records for auditing, suggested readings for audit committees, and audit forms. (MAP)

154. DUNN, Helen W. and MORGAN, Elizabeth M. *The Nursing Audit*. National League for Nursing, New York, N.Y. 1968, 38 p.

This book is a summary of the nursing audit as it functions as an evaluation tool and an outline of its evolution, based upon the experience of the Department of Nursing at the University of Illinois Research and Educational Hospitals. (RJB)

155. MEYER, Thomas. *A Feasibility Study in Determining Individual Practice Profiles of Physicians As A Basis for Continuing Education of These Physicians Utilizing a Postgraduate Perceptor Technique. Final Report*. Univ. of Wisconsin, Madison, Wisc. 1970. 32 p.

The purposes of this project were to develop a profile of the individual physician's practice, test the physician in the major areas of his practice, and provide educational consultation according to practice profile and test results. A test bank of 1,800 5-option multiple-choice questions was classified into 18 categories based on classification of diseases, with three levels of sophistication represented in each category. Questions from about five categories were randomly selected for each of 37 participating physicians. Each physician's categories were determined from his practice profile, which was determined in a week of observation by a medical secretary. The resulting data were used by educational consultants, who met with the individual physicians to plan educational programs to meet their needs. The project found that the procedure holds potential as an aid in educational planning by highly motivated physicians, but cautions that it is too narrow to be useful in evaluating physician performance. Also, the test bank, although useful in principle, will require modification before it will succeed in practice. (ERIC/BH)

156. PATIENT CARE. "Your Practice Skills and Deficits," and "Which Conditions Occupy Most of Your Time?" *Patient Care.* May 15, 1971. pp. 39-149.

These two articles give a description of the Individual Physician Profile (IPP), as described in the previous item by Thomas Meyer, and then go on to provide an aid for the individual physician to adapt it to his use. (RJB)

157. McNABB, Betty Wood. *Medical Record Procedures in Small Hospitals.* Steck-Warlick Co., Austin, Tex. 1970. 157 p.

The author first fashioned this manual in the early period of the Hill-Burton hospitals when medical records departments were being developed and on-the-job training was needed. That version has been updated to meet problems such as Medicare and new requirements in accreditation. McNabb writes that the medical record consists of "sufficient data written in sequence of events to justify the diagnosis and warrant treatment and end results." Her manual includes all areas needed by new medical record clerks; the relationship between medical staff and medical record librarians; the confidential aspect of medical records; medical records in extended-care facilities; the course of the record in the hospital; admission and discharge procedures; and monthly and annual reports. It includes illustrations and sample charts. (MAP)

158. HORTON, Caroline, MINCKLER, Tate M. and CADY, Lee D., Jr. *Medata: A New Concept in Medical Records Management.* Univ. of Texas, Austin, Texas. 1967. 42 p. Presented at the Fall Joint Computer Conference, Nov. 1967.

MEDATA, an automated medical records system, represents an organized approach to the collection, storage, and retrieval of medical data. This completely user-oriented system takes advantage of the background and training of the medical secretary and simultaneously bypasses the conventional keypunch operators and coders. It is capable of responding directly (in his own terminology) to the user who lacks extensive computer background. The system is inexpensive to maintain, and the programs and basic system concepts are machine independent. (NTIS/Author)

1 CONTINUING EDUCATION FOR HEALTH MANPOWER

1.11 Components of the Continuing Education Process
1.112 Priorities, Needs, Goals and Objectives

2. ADULT AND CONTINUING EDUCATION

3. PREPARATORY EDUCATION

4. HEALTH-CARE SERVICES

159. WILLIAMSON, John W., ALEXANDER, Marshall and MILLER, George E. "Priorities in Patient-Care Research and Continuing Medical Education". *Journal of the American Medical Association.* Oct. 25, 1971. pp. 564-569.

The authors describe a three-step method for determining priorities developed at the Rockford, Ill., Hospital. The three steps are: (1) the determination of needs by the use of data and the ranking of them in an order of priorities by

agreed-upon criteria; (2) the determination of the amount of impairment that might be preventable or reparable by current knowledge and resources; and (3) the determination of the extent to which the preventable or reparable impairments were not prevented or repaired. This way of determining priorities of needs leads naturally into the cycle of standard-setting, research into performance, and so on, laying the basis for continuing educational programs to remedy demonstrated and quantified "deficits" in performance. (RJB)

160. PATIENT CARE. "The First Three Steps to Better Continuing Education". *Patient Care*. May 15, 1971. pp. 28-35.

This is the report of a roundtable discussion which considered the necessary elements of continuing medical education from the planning stage to the beginning of the practitioner's program. Participating were directors of continuing medical education representing medical schools, hospitals, the voluntary health agencies, and the Regional Medical Programs. The editor of *Patient Care* and two practitioners involved in continuing education completed the panel. The panel arrived at three steps: identification of the type of care most often given, identification of weaknesses, and identification of objectives for the practitioner's continuing education. They saw ways to overcome barriers by setting aside a certain number of working hours for continuing education each year and utilizing assistants to increase free time. (MAP)

161. CASTLE, C. Hilmon and STOREY, Patrick B. "Physicians Needs and Interests in Continuing Medical Education". *Journal of the American Medical Association*. Oct. 14, 1968. pp. 611-614.

Castle and Storey report an attempt made in Utah to get physicians to express their educational needs. Collaborating were the AMA's Department of Postgraduate Programs, the University of Utah College of Medicine, the Utah State Medical Association, and community hospitals in the state. The first objective was to secure preliminary information on each individual physician which could then be used by him and his educational advisor to analyze his educational needs and to structure an educational program. A second objective was to gather information about Utah physicians as they formed "clusters" of the practicing profession so that plans could be made for a comprehensive continuing medical education program. A questionnaire completed by the physician provided the study base. Forty-six percent of the inventories were returned (a high return, since there was no followup). It had five parts: professional characteristics, circumstances under which the physician practices, opportunities in continuing medical education available to the physician, the physician's perception of his educational needs, and the patient-problems encountered in his practice. From the results, Castle and Storey make several observations: (1) Responses indicated that the main obstacle to continuing medical education is the press of work; (2) needs vary according to the specialty orientation of the physician; (3) group interests or needs in continuing education cannot be generalized; statements must be individualized; (4) since much time was spent by the practitioner with seemingly minor medical problems, the authors suggest that a practical concern of continuing medical educators might be the development and provision of a medical assistant. (MAP)

162. CENTER FOR RESEARCH ON UTILIZATION OF SCIENTIFIC KNOWLEDGE (CRUSK). *"Michigan Physicians":* A Series of Articles from *Michigan Medicine.* Univ. of Michigan. Institute for Social Research, Ann Arbor, Mich. 1970-71. A CRUSK-ISR Reprint.

This reprint is available from CRUSK-ISR (Institute for Social Research), P.O. Box 1248, Ann Arbor, Michigan 48106. It is one of the most carefully planned studies of group characteristics and group needs for continuing education that has ever been made, as deserving of study for its methods as for its findings. The articles were published as follows:

"The Michigan Physician and His Continuing Education," *Michigan Medicine,* November, 1970. "The Michigan Physician: His Work Needs and Opportunities," *Michigan Medicine,* December 1970. "The Michigan Physician's Use and Evaluation of His Medical Journal," *Michigan Medicine,* January 1971. "The Michigan Physician: His Use and Evaluation of the Professional Meeting and PG Courses," (Post Graduate Courses), *Michigan Medicine,* February 1971. "The Michigan Physician: His Education Through Face to Face Contacts and Technical Media," *Michigan Medicine,* March 1971. "The Michigan Physician· His Perception of Competence, Worries and Obsolescense," *Michigan Medicine,* April 1971. "The Michigan Physician and Continuing Education: Looking to the Future," *Michigan Medicine,* May 1971. "The Michigan Physician and His Continuing Education: Summary and Conclusion," *Michigan Medicine,* June 1971.

The principal investigator for the study was Floyd Mann, Ph.D.; Anthony Reilly, Ph.D., and William Morris, Ph.D., were responsible for the direction of the project on a day-to-day basis; Neal Vanselow, M.D., collaborated in the design and review of the work; John Kotre, Ph.D. helped analyze and write up the findings. Mann, Reilly, Morris and Kotre are of CRUSK, and Vanselow is with the Department of Post Graduate Medicine, The University of Michigan.

The study was a two-phased operation that began in the fall of 1968. The first phase was a survey of the attitudes and opinions of physicians regarding continuing education. The second phase was designed to identify the more active and influential physicians in the formal and informal information exchange systems that exist within medical staffs and to learn what distinguished these men from their colleagues. The exacting procedures followed and the many findings and their implications should be studied in detail. The "Final Comment" of the authors follows:

The picture of the Michigan physician that emerged from these data was of a hard-working professional, pressed by the lack of time, strongly motivated to keep abreast of developments in medicine but often disappointed that he was unable to do so.

The data led to a number of conclusions about continuing education techniques—the *how* of education. Periodical reading and attending professional meetings were highly valued methods of education. The traditional lecture was evaluated more positively than we had anticipated. More quality journals appear to be needed for the generalist; audio tapes, study groups, and journal clubs might profitably be used more extensively. One cannot assume that physicians are presently eager to adopt innovations involving new hardware, such as two-way radio or TV. The same can be said of clinical training programs of several weeks or months in length. The evidence indicates that innovations which can be implemented in the immediate work environment of the physician would be received quite favorably.

Even more significant than data regarding the *how* of education were findings concerning the *who*-whose educational needs might be met more adequately and who might increase their capability as educators. The data, in other words, turned our attention to certain groups which planners should concentrate on if the total flow of medical information throughout Michigan is to be facilitated.

The first of these groups is medical doctors in general practice. . . .

The second group consists of doctors of osteopathy. . . .

The final group of interest is composed of criterion physicians, -doctors' doctors and informal/formal consultants Young, highly motivated, confident of their ability, already far advanced professionally, these physicians appear to be important not because more educational effort needs to be directed their way but because they have a great deal of potential as educators. Indeed, one might say that they are the key to improving the educational picture in Michigan. They are in touch with the best sources of medical information and they are already serving in some capacity as on-the-spot educators of their colleagues. If their skills as educators can be significantly improved, and if they can turn more of their attention to the educational needs of the generalist, they will provide that unique resource that could lead to dramatic improvement in the quality of education at the point where most physicians want it-in their immediate environment. (RJB)

163. CALLAN, Laurence B. and others. "Twelve-State Survey of Needs and Interests in Continuing Education in Public Health". *Public Health Reports.* Aug 1969. pp. 741-755.

Using a mailed questionnaire, the Program of Continuing Education in Public Health (a partnership of professional schools) surveyed educational needs and interests among 2,534 public health professionals in 12 western states. The 1,355 who responded made two choices from a list of 78 courses grouped in eight broad categories. Twenty percent or more chose 19 courses ranging from "Motivation and Persuasion Techniques for Use with the Legislature, and Professional, the Public" (38 percent) to "Prevention and Control" and "Community Services" (20 percent each). Respondents were concerned with general problems, not specific diseases or narrow subjects, and with improving skills in organizational and community problem solving. They overwhelmingly favored video tapes and telephone tieups as supplements but resisted the use of teaching machines. The majority preferred courses designed for multi-disciplinary audiences. Choice of courses depended greatly on one's administrative level. Past participation was linked to greater age and tenure, higher position, higher educational level, and membership in professional organizations. Of those in full-time professional posts, 66 percent lacked a public health degree. One reference and nine tables are included. (ERIC/LY)

164. DUBIN, Samuel S. and MARLOW, H. LeRoy. *The Determination and Measurement of Supervisory Training Needs of Hospitals Personnel. A Survey of Pennsylvania Hospitals.* Pennsylvania State Univ. Continuing Education, University Park, Pa. 1965. 148 p.

More than 6,000 persons-administrative, supervisory and professional personnel-in 213 hospitals responded to questionnaires and more than 600 others were interviewed. They identified as their most prominent need

improvement in all aspects of supervisory performance. Many supervisors had been promoted with little or no preparation. Specifically they identified needs in dealing with new dimensions of patient care, the changing role of the nurse, the handling of medical records, and the proper uses of equipment and supplies, and the fundamentals of nutrition. These needs were organized in reports on nursing service and nursing education, clinical and radiology laboratory service, medical records department, dietary department, engineering and maintenance, business office and purchasing, personnel directors and institutional care departments.

These needs were similar in many respects to those identified in 1956 by the Catholic Hospital Association, reported by W. I. Christopher, "Project 1997," *Hospital Progress*, Nov. 1961. Nearly 2,000 supervisors and other high-level personnel representing 281 hospitals were asked, in interviews, conferences and by mail, to list what they needed to learn to do their jobs more effectively. They identified how to build better employee relations, how to communicate, how to be a manager or administrator, rather than principles or general knowledge. A later survey, reported by E. J. Spillane, "A Survey Report on Personnel Directors," *Hospital Progress*, Nov. 1966, revealed that of 371 hospitals responding, 21 percent had no training programs for nonsupervisory employees, and 40 percent had none for supervisory personnel. (RJB)

165. PATIENT CARE. "From West Virginia: The Doctor's Office Becomes His Classroom". *Patient Care*. May 30, 1971. Vol. V, No. 10. pp. 39-43.

"Better patient care in the office is the object for volunteers in West Virginia. Physicians set their own criteria for patient care, select their own peer, and have their records audited against their own criteria. The technical details of this pilot project are handled by trained personnel outside the doctor's office, keeping him free for his daily work." This is an account of the plan that Daniel Hamaty, M.D., internist and active member of the West Virginia State Medical Association, has been developing since 1968. His plan is funded by the WVMA and later by the Regional Medical Program. It is called the West Virginia State Medical Association's Project of Continuing Education of West Virginia Physicians Through a Voluntary Self-Audit–Peer Review of Patient Care. Stage One: The audit-trainer of the project analyzes a physician's practice and provides him with a practice profile. From this profile the physician chooses a disease or condition he would like to study and, with the help of Hamaty, sets criteria. Stage Two: The doctor chooses a single peer to work with him, drawn from the membership lists of members of the various sections of the WVMA who have agreed to cooperate. The doctor sends his criteria to the peer, who reviews them and returns his critique. The doctor accepts or rejects the critique (if he rejects, he can choose another peer to review). Then the doctor chooses someone in his community or office to be trained by the project audit-trainer. This person audits the records for the chosen disease or condition against the doctor's criteria. If he did not do as well as he thought he should, he can ask for a supplemental audit to pinpoint the reasons. Stage Three: The results of the audit are sent to the peer reviewer for comment. Finally, when the comments are returned, the physician is asked to decide whether he believes he needs more education, a change in office management, or a change in patient management. If he says yes to any of the three questions, the project staff will help work out a plan for change. Regardless of the answer, the physician is asked again after 30 days and also

after 90 days if he did make plans for education or changes in patient or office management. (RJB)

166. PATIENT CARE. "Peer Review: What it is Designed to Accomplish". *Patient Care.* Nov. 15, 1971. pp. 42-61.

This article is based on a roundtable discussion by physicians and representatives of "third parties" who have wrestled with the problem of peer review. The panel members agreed that the purpose of peer review is to improve quality, to expand services and to control the costs of health care. A major goal is the education of physicians who are deficient in certain areas. Both too much and too little use of hospitals were considered. A peer review should encompass both in-hospital and ambulatory care. The decision to promote peer review usually originates at the state level but the review itself to succeed must be conducted on a local basis. It should be carried out on a metropolitan or multi-county basis to get adequate physician participation and to minimize personal conflicts. At least 20 physicians are required for a committee and in some areas 50 might be considered minimum. The sole function of a national medical organization is to provide stimulus for the process. (MAP)

167. SCHLESS, James M. "Peer Review as an Educational Challenge". *Journal of the American Medical Association.* Feb. 21, 1972. pp. 1960-1961.

This editorial by the director of the Office of Postgraduate Medical Education, University of Minnesota, contends that peer-review mechanisms can, and must, do more than monitor patterns of utilization and police individual cases of poor care. Peer review can be the "most effective single instrument of continuing education, and thereby of quality maintenance." Schless suggests that the best way to accomplish this is on the local level, using an educational chart audit in the community hospital, by which actual performance can be objectively compared to optimal patterns of care. Educational shortcomings can then be recognized and remedied on a voluntary, impersonal and nonpunitive basis. (MAP)

168. AMERICAN MEDICAL ASSOCIATION. *Peer Review Manual. Volumes I and II.* The American Medical Association, Chicago, Ill. 1972

These were prepared by the Division of Medical Practice, Department of Insurance and Practice Management of the American Medical Association. The staff presents the major considerations for the successful implementation of peer review, which it defines as "the evaluation by practicing physicians of the quality and efficiency of services ordered or performed by other practicing physicians." The volumes include a history of peer review and its organization; eight steps for implementation, funding and staffing; utilization review; and legal considerations. Eight appendices include the AMA's guidelines for establishing medical society review committees, state and county examples of peer review programs, samples of criteria studies for use in peer review, data sources, legal information and examples of non-profit corporations performing peer review. The editor gives a glossary of relevant terms. The volumes are loose-leaf, thus enabling constant revision. (RJB)

169. LAVENTURIER, Marc. "Utilization and Peer Review by Pharmacists". *Journal of the American Pharmaceutical Association.* April 1972. pp. 166-170.

The author is vice president for professional services for Paid Prescriptions, a nationwide nonprofit drug service contractor. In this article he describes the activities of a Drug Utilization Review Committee (DURC), formed in August 1970 in the San Joaquin, California, area, to be concerned not only with the rapid reimbursement of pharmacy claims but also the improvement of the pharmacist's professional function. Its premise was, "Pharmacists must maintain professional control in all Public Third-Party Drug Programs in which they participate for the benefit and protection of the patient." The committee identified seven characteristics essential to the drug utilization review process: local control, peer activity, multidisciplinary, scheduled activity, power to act, education, and legal status and immunity. DURC has four pharmacist members and a physician member. The scheduled activity deals with claim review, professional review, and peer review. DURC's primary objective is to achieve the optimum utilization of drugs and the highest possible standards of patient drug care. It relies primarily upon persuasion but has the power of coercion by reporting to authorities. "Peer review in pharmacy is a pioneer venture and the committee has wisely chosen to proceed with care[illegible]n and discretion. Drug utilization review is an equally new field [illegible]or for us and everyone connected with the process is caught in the excitement of discovery and learning. We have now reached the point when we must share our experiences with our colleagues through the publication of our results and recommendations. . . Those of us who have participated in peer review believe that we may well be preserving pharmacy's right to control its own destiny at this critical time in our history." (RJB)

170. AMERICAN HOSPITAL ASSOCIATION. *Employee Performance Appraisal Programs: Guidelines for their Development and Implementation.* American Hospital Association, Chicago, Ill. 1971. 17 p.

These guidelines provide a step-by-step methodology for the development and implementation of an effective formal employee-performance appraisal program. The advantages of such programs to management and to employees are discussed, and the pitfalls inherent in any performance-evaluation program are defined clearly. Included are examples of evaluation scales and definitions of terms used in the appraisal function. The basic principles of performance-appraisal techniques stated in the manual are applicable to all types of systems. (JAHA)

171. DYCHE, June. "Accountability in Inservice Education". *Journal of Continuing Education in Nursing.* Jan./Feb. 1972. pp. 27-30.

The inservice education department must be accountable for the quality and outcome of the educational programs mounted in behalf of the nurse-practitioner who must be continuously learning. Measurement of performance should be based on performance of the individual relating to a standard. (ERIC/Author/EB)

172. MAGER, Robert F. and PIPE, Peter. *Analyzing Performance Problems, or 'You Really Oughta Wanna'.* Fearon Publishers, Belmont, Cal. 1970. 117 p.

The correct diagnosis of an unsatisfactory performance is crucial to the achievement of both institutional goals and educational goals. It is crucial also

to the proper use of education/training as a managerial strategy and to the solid basing of education/training upon demonstrated needs. Misdiagnoses range all the way from assuming that the cause is an educational deficit when it may be something else, such as flaws in managerial, administrative or supervisory procedures, to assuming that the nature of the educational deficit is cognitive when it is something else. The authors distill their analysis in a "Quick Reference Checklist," on pages 101-105, with parallel lists of "Key Issues" and "Questions to Ask" that move the analysis from the first awareness that there may be a performance problem to the final issue, "Which solution is best?" and the final question, "Which remedy interests us most?" (RJB)

173. MAGER, Robert F. *Developing Attitudes Toward Learning.* Fearon Publishers, Belmont, Cal. 1968. 104 p.

The author argues convincingly that the effect a course or educational program has upon the learner's attitude toward learning is more important in the long run than what he learns specifically during the experience. In his usual lucid, concrete way Mager explains how the development of favorable attitudes toward learning can be made a specific goal, translated into a specific objective and evaluated as precisely as other objectives. (RJB)

174. MAGER, Robert F. *Goal Analysis.* Fearon Publishers, Belmont, Cal. 1972. 136 p.

A goal is farther-range and less precise than an objective but there are systematic ways of describing and defining it. Mager expounds these ways. This book is a companion one to the next item on this bibliography. (RJB)

175. MAGER, Robert F. *Preparing Instructional Objectives.* Fearon Publishers, Belmont, Cal. 1961. 62 p.

The author gives hard-headed, clear, step-by-step guides on decisions concerning exactly what one intends an instructional course or program to accomplish, what are the most likely ways to get the results desired, and what the assessment of results should be. This book is a companion to the immediately preceeding one in this bibliography on "goals." (RJB)

1. CONTINUING EDUCATION OF HEALTH MANPOWER

1.11 Components of the Continuing Education Process
1.113 Methods, Modes, Media and Devices

2. ADULT AND CONTINUING EDUCATION
3. PREPARATORY EDUCATION
4. HEALTH-CARE SERVICES

176. RASER, John R. *Simulation and Society: An Exploration of Scientific Gaming.* Allyn and Bacon, Inc., Boston, Mass. 1969. 180 p. Methodology in the Behavioral Sciences Series.

In this volume the author provides a definition of the technique of simulation in order to examine the relevance of this technqiue for research in the social

sciences. He looks into the philosophical and epistemological bases of simulation, examines its intellectual roots, and illustrates its use in a variety of disciplines–economics, political science, sociology, education, psychology, anthropology, and law. He shows how the technique may be used as an aid to theory building; and how it has been applied to training, teaching, and experimental research. He discusses a means of assessing the validity of simulations and demonstrates the interrelated qualities of usefulness and validity. A bibliography and a subject index are provided. (ERIC/LY)

177. PRESCOTT, Suzanne. *The Impact of Workshops on Practitioners: A Current Evaluation.* American Psychological Association, Washington, D.C. 1970. 73 p.

For the mental health practitioner to keep abreast of his rapidly changing field requires that adequate, up-to-date information be sufficiently available to meet professional needs. This study attempted to identify the ways in which such information is gathered at workshops. The characteristics of participants in a series of 1969 Post Doctoral Institutes is described–their clinical experience, professional affiliations, and previous experience with material in the areas of their workshops. The formats used in workshops are rated according to importance or utility. The impact of the workshops on the participants is surveyed. Some suggestions are offered for improvements in workshops. Seven workshops are described in capsule form to illustrate the general points made previously. Included in the appendices are samples of information gathering material, a list of suggestions for workshops planners, and a suggested planning sequence. (ERIC)

178. HOSPITAL RESEARCH AND EDUCATIONAL TRUST. *Correspondence Education and the Hospital.* Hospital Research and Educational Trust, Chicago, Ill. 1969. 55 p.

Based primarily on questionnaire responses from 423 hospitals in the United States, this study dealt with noncredit correspondence courses designed to upgrade hospital personnel job skills and raise job performance and/or job level. It inquired into uses of correspondence as noted in the literature; awareness and use of the method in hospitals; hospital policies on educational programs for employees; advantages and disadvantages of correspondence study as perceived by hospital administrators; preferred training methods for various levels of personnel; areas of departmental training need, and the interest in meeting these needs by correspondence study; specific course evaluations by course completers, dropouts, supervisors, and experts; and expert opinions on the use and effectiveness of various types of correspondence study. It was recommended that a central agency focus its attention on documentation, research and experimentation, course improvement, and other facets of correspondence education for hospital personnel. (The document includes 34 tables, 28 references, and a list of information sources.) (ERIC/LY)

179. KNIRK, Frederick G. and CHILDS, John W., Editors. *Instructional Technology: A Book of Readings.* Holt, Rinehart and Winston, Inc., N.Y. 1968. 300 p.

A set of 31 articles has been organized to provide a basis for understanding instructional technology–the use of instructional methods as they are integrated into the total program system. Several major areas are examined: the

social and cultural implications of technology; the characteristics of readily available audiovisual media and their associated materials; instructional systems concept; the theory of information storage and retrieval and techniques related to instructional technology; the influence of school plant design on the use of media; the effect of media and materials on the economics of instruction; and learning and communication theory as related to the use of media. Some of the readings provide a bibliography. (ERIC/JY)

180. BRETZ, Rudy. *A Taxonomy of Communication Media.* Educational Technology Publications, Englewood Cliffs, N.J. 1971. 165 p.

Bretz wrote this book as a contribution to two Rand Corporation projects, one concerning Air Force instructional systems, the other concerning biomedical information for the Lister Hill Center for Biomedical Communications. Aimed at users and practitioners, it defines, describes and classifies communication media, and makes important distinctions. Bretz defines a communication medium as "a system for conveying messages through reporducible and self-contained programs." The message is *not* the medium. "There is nothing to be gained . . .by using message to mean the general social importance or significance of the medium. We shall use message as everyone else does, to mean the information which is communicated and the medium to mean the means whereby communication is accomplished." Bretz distinguishes a communication medium (1) from a transmission or recording component, (2) from communication aids, and (3) from "multimedia applications." He proposes a two-dimensional classification system. It divides the media horizontally into two groups—telecommunication and recording; and vertically into seven groups—audio-motion-visual, audio-still-visual, audio-semimotion, motion-visual, still-visual, audio, and print media. Using this classification, Bretz defines and describes in essential detail 28 specific communications media, including all the major ones now or soon to be available. His main attention is to instructional uses. "It is only within the context of the user system that a communication system can be evaluated. No value judgment as to the success or failure, the efficiency, feasibility, or effectiveness of either a communication system or an individual communication can be made from a point of view which is strictly within the system itself. The purpose of communication is inherent in the user system; the communication medium, in one way or another, helps the user system to function." ". . .instructional *method* is far more significant than instructional *medium.* A good application of a communication medium in instruction is characterized by thorough integration of (1) program design and production, (2) medium of transmission or recording, and (3) display equipment configuration, into the instructional method in which it plays a role." The book opens with a glossary of terms and closes with an appendix on the debate "Local Versus Central Production of Program Software in Instructional Systems." (RJB)

181. NATIONAL INSTITUTES OF HEALTH. *National Library of Medicine News.* National Library of Medicine, Bethesda, Md.

So many services for research, health care and education at all levels, particularly continuing education, are available through the NLM, and the capabilities for further services are developing so fast that the reader is advised

to write to the National Library of Medicine Information, 8600 Rockville Pike, Bethesda, Md. 20014, asking to be put on the free mailing list of this monthly publication. Some of the present and developing capabilities with which the continuing educator should be familiar that are available through the NLM and the Lister Hill National Center for Biomedical Communications (see the following item in this bibliography) are: (1) cable television networks used in pilot projects to improve health-care delivery and self-care education in ghetto areas in Denver and New York City; the New England Microwave Network bringing medical school classrooms to the small community hospital; MEDLINE (MEDLARS On-Line), providing an on-line bibliographic searching capability for libraries at medical schools, hospitals and research institutions throughout the country; a wireline network project linking up computer simulation centers; and the NLM literature searches. (RJB)

182. LISTER HILL NATIONAL CENTER FOR BIOMEDICAL COMMUNICATIONS. *Lister Hill National Center for Biomedical Communications Report to Congress.* National Library of Medicine, Bethesda, Md 1972.

The purpose of the Lister Hill National Center for Biomedical Communications is to adapt existing techniques and develop new computer and communication technologies for incorporation into operational biomedical communication networks in support of health-care delivery, education and research. Among the projects summarized in this report of the first three years of operations are satellite networks, cable television networks, the New England Microwave Network and wireline networks. The report is available without charge from the NLM's Office of Public Information, 8600 Rockville Pike, Bethesda, Md. 20014. (RJB)

183. CARNEGIE COMMISSION ON HIGHER EDUCATION. *The Fourth Revolution: Instructional Technology in Higher Education.* McGraw-Hill Book Co., Hightstown, N.J. 1972. 106 p.

Although this report focuses on higher education, it recognizes that, "Off-campus instruction of adults may become both the most rapidly expanding and the most rapidly changing segment of postsecondary education." In this area the movement of instructional technology from experimentation to general use will probably precede the movement in higher education. The Commission observes both that, "The new technology will have a centralizing effect" and that it will "increase the opportunities for independent study and provide students with a richer variety of courses and methods of instruction." Many of the goals and some of the recommendations in this report have implications for the continuing education of health manpower: particularly the goal that by 1980, "At least three cooperative learning-technology centers, combining the instructional technology capabilities of many member institutions within a geographic region, and originating and directing centralized instructional services through information, communication, and computing networks will be in operation." and the goal that "systems for identifying promising instructional materials will have been developed and procedures for encouraging their development and utilization will be operable," and the recommendation that a major thrust be "toward the development and utilization of outstanding instructional programs and materials." (RJB)

184. MILLER, George and HARLESS, William G. *Instructional Technology and Continuing Medical Education.* Academy for Educational Development, Inc., Washington, D.C. 1970. 27 p.

How has continuing medical education fared under instructional technology? For this reappraisal, the authors review the use of tapes, slides and film, in the medical profession in the U.S. and in the British Isles; radio and telephone, television, programmed instruction, and computers (in their three-fold functions as retrievers of information, consultant in the diagnostic process, and an instrument of instruction). Medical educators, the authors conclude, have embraced instructional technology with enormous enthusiasm, but have not done it systematically, seeming to have replaced their customary spirit of inquiry with a spirit of faith. They have neglected the process of diagnosing their needs, following it up with a specific prescription to correct the diagnosed defect, and a careful observation to determine whether the intervention has been effective. (ERIC/Author/GO)

185. PUBLIC HEALTH SERVICE. BUREAU OF DISEASE PREVENTION AND ENVIRONMENTAL CONTROL. (DHEW) *Toward Improved Learning: A Collection of Significant Reprints for the Medical Educator.* National Communicable Disease Center, Atlanta, Ga. n.d.

This volume is a collection of papers exploring developments in communications media for improved learning by scientist-educators. They include information on various communications methods, both proven and experimental, which are utilized by several health sciences, including medicine, dentistry, veterinary medicine, nursing, hospital administration, and public health. The volume is separated into the following sections: Overview, Audio Tape, Computer, Film, Programmed Instruction, Radio, Television, Miscellaneous, and Multi-Media. (RJB)

186. MANN, Joe and HENDERSON, Jim, Editors. *Catalog of Audiovisual Materials Related to Rehabilitation.* Auburn Univ. Alabama Rehabilitation Media Service, Ala. 1971. 353 p.

Selected from over 200 audiovisual catalogs, this catalog provides an annotated listing of audiovisual materials related to social-rehabilitation process. The major portion of the materials has not been screened. The materials cover such subject areas as: adjustment (job readiness, personal-social, and work); age changes; alcoholism and drugs; diseases; mental and physical health; marital status; homemaking; therapy and rehabilitation; and vocational training. (ERIC/EB)

187. COOPER, William. *Role of Audio and Audio-Visual Materials in Enhancing the Learning Process of Health Science Personnel.* Interuniversity Communications Council (ECUCOM), Princeton, N.J. 1969. 26 p.

The material presented here is the result of a review of the Technical Development Plan of the National Library of Medicine, made with the objective of describing the role of audiovisual materials in medical education, research and service, and particularly in the continuing education of physicians and allied health personnel. A historical background of the use of audiovisual materials in medical and health professional education is given.

The benefits and problems of resource sharing with other institutional producers of audiovisual material in health science education, the facilities, equipment, and capabilities required for extended use of these materials are described. The potential role of the Biomedical Communications Network is discussed and a description of a typical learning resource center in a medical school is provided. (ERIC/JY)

188. ABRAHAMSON, Stephen and others. *Medical Information Project: A Study of an Audiovisual Device as a Technique for Continuing Education for General Practitioners. Final Report.* Univ. of Southern California, School of Education and School of Medicine, Los Angeles, Cal. 1970. 408 p.

The unique factor in the Medical Information Project is that working from ground zero, it undertook to design and put into operation a communication system for general medical practitioners using an individualized, programmed, audiovisual medium. The development of this system involved three general phases. Phase I consisted of: (1) obtaining and reviewing literature pertaining to medical communication problems; (2) designing a means of sampling, drawing the sample, obtaining the physicians' participation; (3) laying out the general design for research and development; (4) developing and validating the instruments to be used to assess the physicians' cognitive and affective reactions; (5) testing and selecting the hardware to be used as the communication device; (6) developing the programming concepts; (7) developing the production process and (8) selecting the content areas and the medical consultants for the program topics. Phase II consisted of (1) distributing the hardware to the participating physicians, (2) producing and distributing the training program on equipment utilization, (3) pre-and post-program questionnaires and interviews and (4) producing and distributing the fifteen content programs. Phase III consisted of: (1) collecting and processing raw data, (2) analyzing the data and (3) writing the final report. (ERIC/Author/NH)

189. BIRD, Kenneth T., CLIFFORD, M. Henry and DWYER, Thomas F. *Teleconsultation: A New Health Information Exchange System.* Massachusetts General Hospital, Boston, Mass. 1970. 58 p.

Teleconsultation is the "exchange of clinical information between widely separated health professionals, e.g., ambulance and hospital." This is a 1969 report of a demonstration at Massachusetts General Hospital that shows how two-way telecommunications circuitry can facilitate professional consultations. It identifies the circuitry and support systems, and the professional interrelationships needed if teleconsultation is to become part of future health information systems. (MAP)

190. UNIVERSITY OF ALABAMA *"MIST" Program.* Division of Continuing Medical Education, University of Alabama School of Medicine, Birmingham, Ala.

No recent report seems to be available of the pioneering Medical Information Service via Telephone (MIST) program developed by the University of Alabama School of Medicine and the Alabama Regional Medical Program, which several states have now adopted or adapted. Among its objectives are (1) to improve patient care; (2) to aid the practitioner at the time he needs help with a particular patient problem; (3) to reinforce this assistance with

pertinent library material; (4) to provide communication between practicing physicians and the faculty of the University of Alabama Medical Center; and (5) to provide direction to the University's Division of Continuing Medical Education by identifying educational needs. By means of the state-wide WATS lines and centrex tie-lines, immediate person-to-person consultation is available 24 hours each day. Telephone operators with a directory of participating faculty members route calls. Each call is taped and analyzed. When appropriate, the Medical Library sends pertinent literature to the caller within three days. For further information write to Margaret S. Klapper, M.D., Division of Continuing Medical Education, University of Alabama School of Medicine, 1919 Seventh Ave., South, Birmingham, Ala. 35233. (RJB)

191. DOBBS, Ralph C. and MOWRER, John L. "Updated Party Line for Adult Education". *Journal of Extension.* Fall 1971. pp. 31-34.

The Missouri Telephone lecture network is presently used for extension programming with health professionals. The authors describe how the system works and some of its advantages. They also describe how this educational technique might be applied to many adult groups. (ERIC/MS)

192. NILES, Anne G., COOPER, Signe S. and ASTHANA, Martha. *Definitive Dialing. . .Nursing Dial Access.* Univ. of Wisconsin. Department of Nursing. University Extension, Madison, Wisc. 1970. 63 p.

The program, available on an around-the-clock basis, provides short tapes on a variety of nursing and medical subjects and may be used from any telephone, free of charge to Wisconsin callers. The library presents core information in the categories of nursing care emergency situations, new procedures and equipment, recent developments in nursing and legal aspects in nursing. Nursing Dial Access averages 1000 calls a month. A survey of the users indicated that the program has been found to be an appropriate way to provide certain types of information, nurses have accepted this information retrieval system, and the program has been successful in meeting its purpose—to assist nurses outside the metropolitan areas of the state. (Appendixes include a bibliography of tapes, guidelines for developing dial access libraries, and lists of tapes available to states other than Wisconsin.) The Wisconsin Physician's Dial Access Library pioneered this medium and found it to be a feasible one for the distribution of information. The nursing program has enlarged the scope of the Service in Wisconsin, and both programs have assisted others in developing similar services. Two other accounts of NDA are "Dial-a-Tape for Continuing Education," by Anne McKee Niles, *NUEA Spectator,* v. 36, n. 7, 18 pp., March, 1972 and "Dial N for Nursing," by Signe S. Cooper and Ruth S. Lutze, *Adult Leadership,* v. 19, n. 6, 4 pp., December, 1970. (RJB)

193. AMERICAN SOCIETY OF CONTEMPORARY MEDICINE AND SURGERY. *"MediCall"* Chicago, Ill.

The first nationwide physician's information service began July 15, 1972—too recently to be included in the literature reviewed for this bibliography. The idea for the service, "MediCall," was conceived by John G. Bellows, a Chicago

opthalmologist and secretary of the American Society of Contemporary Medicine and Surgery (ASCMS), which sponsors the service. It is patterned after the MIST program, which serves Alabama physicians. Service is provided 24 hours a day every day to all doctors in the continental United States who want information from an experienced specialist in a particular field. MediCall has obtained the services of 80 specialists. A doctor wanting information may place a call to the MediCall Headquarters in Chicago, where specially trained telephone operators put him in touch with one of the specialists within minutes. The service may particularly benefit doctors in remote areas. The ASCMS, sponsor and subsidizer, hopes that the program will become self-sustaining. The physician seeking information pays for the telephone call and there may be a fee of $5 to $10 for the information, a portion of which goes to the specialist (although some contribute their services) and a portion to the ASCMS. For more information, write John G. Bellows, M.D., 30 N. Michigan Ave., Room 1600, Chicago, Ill. 60602. (RJB)

194. ASSOCIATION OF MEDICAL TELEVISION BROADCASTERS *Catalog of Educational Programs.* Association of Medical Television Broadcasters, Inc., Los Angeles, Cal. 1971. 99 p.

The Association of Medical Television Broadcasters (AMTvB) was formed in 1964 during an Invitational Conference of Postgraduate Medical Education. At that time, nine medical institutions were producing medical television tapes for broadcasting. The purposes of the Association are to promote collaboration in the production, broadcast and exchange of recorded medical programs; to encourage and assist other institutions in the use of broadcast television in continuing medical education; and to acquire, evaluate and disseminate information about the use of broadcast television in medical education. This catalog lists programs produced at the University of California, (L.A.), the University of Oklahoma, the Medical University of South Carolina, the University of Washington, the University of Western Ontario, and Instituto Mexicano del Seguro Social. Programs listed fall under the headings of: internal medicine and medical subspecialties, surgery and surgical subspecialties, pediatrics, obstetrics and gynecology, psychiatry, public health, medical education and research, dentistry, pharmocology, trauma, oncology, and nursing. (MAP)

195. MEYER, Thomas C., HANSEN, Richard H. and KELLHER, Jerry J. "Report of an Experiment in the Use of Telelectures for the Continuing Education of Physicians and Allied Health Personnel". *Journal of Medical Education.* Jan 1968. pp. 73-77.

A pilot project to provide continuing education to Wisconsin physicians via telephone circuit was initiated by the University of Wisconsin in November 1965. The Department of Postgraduate Medical Education of the University of Wisconsin Medical Center and University Extension designed it with the following objectives: (1) to offer instruction of the highest caliber; (2) to be truly continuing; (3) to incorporate topics directly applicable to clinical practice; (4) to be of low cost to the physician; and (5) to reduce substantially the time the physician need absent himself from his practice to participate in a continuing education program. The program format was modeled along the lines developed by Dr. Frank Woosley and his associates at Albany (N.Y.) Medical College for use on their two-way radio conferences. Coverage of subject matter in the curriculum was designed to incorporate topics directly

applicable to clinical practice. Physicians were asked to evaluate each program and a roll was taken at each session. The Academy of General Practice credits each physician with the number of hours he attends. The evaluation of the project was that the method is promising. (MAP)

196. PRYNNE, T.A. *Handbook on Hospital Television.* Educational Resources Foundation, Columbia, S.C. 1972. 104 p.

Designed for both hospital and audiovisual personnel, this handbook is a survey of what's being done with television within the medical profession. Following an introduction answering technical questions, the handbook goes into specific illustrations of hospital TV usage in fields ranging from administration to urology. Representative medical TV efforts are recorded from the National Medical Audiovisual Center, The University of Georgia Medical School, Brooke Army Medical Center, Duke University Medical School, the South Carolina ETV Network and Regional Medical Program. Sloan-Kettering Memorial Cancer Institute, the Massachusetts General Hospital and many other medical institutions. Included as an appendix are articles of particular concern to those hospitals establishing television facilities: electronic safety with television, improved reception through distribution systems, and medical television and the law. (RJB)

197. KALBA, Konrad K. *Communicable Medicine: Cable Television and Health Services.* Alfred P. Sloan Foundation, N.Y. 1971. 57 p.

Cable television offers a great potential for the improvement of present health services. A multipurpose cable communications system, adapted to inter-organizational medical uses, could constitute the communications infrastructure needed in the present disorganized state of health-care delivery. Such a system of video and data transmission offers better medical record-keeping, faster medical testing and referral, opportunities for personnel training and continuing medical education for doctors in the community, and opportunities for much improved administrative communication. Ultimately costs would be less and efficiency far greater. Disadvantages of such a system are discussed, along with the examples of the use of cable television in medicine to date. (ERIC/RB)

198. LYSAUGHT, Jerome P., Editor *Programmed Instruction in Medical Education.* The Rochester Clearinghouse for Information on Self-Instruction in Medical Education, Rochester, N.Y. 1965. 245 p.

This is the proceedings of the First Rochester Conference on Self-Instruction in Medical Education, June 25-27, 1964. It summarizes five years of research and development on self-instructional programs at the University of Rochester College of Education later extended to the School of Medicine and Dentistry. It discusses the practical and theoretical aspects of program development, gives descriptions of successful and unsuccessful self-instructional medical program, and considers the philosophical impact of self-instruction on medical education. (MAP)

199. LYSAUGHT, Jerome P., Editor. *Individualized Instruction in Medical Education.* The Rochester Clearinghouse on Self-Instructional Materials for Health Care Facilities, Rochester, N.Y. 1968. 397 p.

The proceedings of the Third Rochester Conference on Self-Instruction in Medical Education, September 14-16, 1967, continues the documentation of the recent trend toward self-learning and self-regulation of the instructional process begun in the first conference in 1964. General discussion areas include: the context of individualized instruction; research studies on learning processes in medicine; the concepts, application and strategy of technology; instructional systems for individualized learning; and programmer training and development. Notable papers are: "The Role of Continuing Education and Programmed Instruction in the Regional Medical Program Setting," by Frank L. Husted; "The Physician's Responsibility to the Patient: Videotape Problem-Solving in a Self-Instructional Mode," by James W. Raney; "Programmed Instruction to Train Hospital Employees How To Train Others," by Shirley Soltesz; and "The Training of Health Programmers for the Health Professions," by Jerome P. Lysaught and Robert G. Pierleoni. (MAP)

200. LYSAUGHT, Jerome P. *Research on the Use of Programmed Instruction Among Adult Learners in Professional Health Fields.* Paper presented at the National Seminar on Adult Education Research, Chicago, February 11-13, 1968. 1968. 15 p.

As part of a University of Rochester effort to explore the use of self-instructional programs and materials in educating doctors, nurses, paramedical personnel, and patients, three studies of program utilization and effectiveness were made. Data were obtained on completion and non-completion of a programmed course on allergies, user reactions as to its usefulness, and attitudes toward the use of more programmed materials. In two studies of programmed instruction in cancer diagnosis, treatment, and patient management, achievement was measured in programmed and conventional instruction. In the allergy program, course completions (87.5 percent), positive reactions (96 percent), perception of practical value (93 percent), and favorable responses on the use of more programmed materials (95 percent) indicated that effective programmed materials would be welcomed by health practitioners. In the cancer program, achievement results showed that programmed instruction taught effectively and in a superior fashion compared to traditional methods. (ERIC/LY)

201. HOSPITAL RESEARCH AND EDUCATIONAL TRUST. *Programmed Instruction and the Hospital, A Report on the Use of Programmed Instruction in Health Care Institutions.* Hospital Research and Educational Trust. Chicago, Ill. 1967. 162 p.

The first section of this report on programmed instruction in the health-care field examines the hospital milieu and such problems as personnel shortages, increased specialization, and strict technical and educational requirements. The second section reviews some recent advances in behavioral technology, fundamental principles of teaching machines, procedures for evaluating program effectiveness, and problems encountered in preparing programmed instructional materials. Current applications in operating room training for instrument nurses and in professional continuing education and patient orientation concerning diabetes are described. In the fourth section, the value of programmed methods for use with inpatients, outpatients, administrative personnel, technicians, and other hospital subprofessionals is discussed. (ERIC/LY)

202. SCOTT, Lou Peveto. *Programmed Instruction and Review for Practical and Vocational Nurses. Volume One: Foundations and Fundamentals of Nursing.* The Macmillan Company, N.Y. 1968.

This should be used with Volume Two: *Clinical and Community Nursing;* together they present information, programmed instruction, illustrations and review questions for comprehensive coverage of practical nursing. In addition to traditional subject matter, these volumes include the areas of orthopedics, rehabilitation, gynecology, mental health, and disaster and emergency nursing. This program was tested in a junior college, a vocational school and technical schools in Florida. They can be used for classroom lectures, self-study material, and licensure examination review. (MAP)

203. STOLUROW, L. M., Editor *Computer Assisted Instruction in the Health Professions.* Entelek, Inc. Newburyport, Mass. 1970 258 p.

This book contains the papers presented at the Harvard Medical School in the sixth of a series of meetings designed to bring together persons interested in exploring ways in which computers might be used to aid instruction. The papers reprinted and edited present various individual's experiences with the use of computer-assisted instruction (CAI) systems, and they report how these systems work. Among the systems mentioned are (1) PLATO (Programmed Logic for Automatic Teaching Operations), designed to teach the student how to gather and evaluate data; (2) The Dial System, to provide "analysis of laboratory data and programmed tutoring in clinical decision theory"; (3) PILOT (Programmed Inquiry Learning or Teaching), for preparing problem-oriented medical records for computer-assisted learning; (4) PLANIT (Programming Language for Interactive Teaching), to enable school personnel to communicate with a computer; (5) Harvard University Computer-based Interactive Instructional System, designed to aid the author-editor in analyzing and modifying an interactive course or laboratory and to deliver individualized instruction. The greatest advantage of CAI is that it can be programmed for individual instruction and for individual student, teacher and health manpower needs. (RJB)

204. CHANDAR, Anthony, GRAHAM, John and WILLIAMSON, Robin. *A Dictionary of Computers.* Penguin Books, Baltimore, Md. 1970. 407 p.

This is a glossary of about 3,000 words, phrases and acronyms, including 70 general articles covering major computer topics and also business topics such as "budgetary control" and "systems analysis." It is designed for both technical and general readers. Technical terms are defined in simple English. There is thorough cross-referencing. At the beginning are an "introduction to computers" and a list of general articles. Each general article ends with a short bibliography. (RJB)

1. CONTINUING EDUCATION OF HEALTH MANPOWER

1.11 Components of the Continuing Education Process
1.114 Evaluation

2. ADULT AND CONTINUING EDUCATION
3. PREPARATORY EDUCATION
4. HEALTH-CARE SERVICES

205. NATIONAL INSTITUTE OF MENTAL HEALTH. NATIONAL CLEARINGHOUSE FOR MENTAL HEALTH INFORMATION (DHEW). *Guidelines for Evaluation of Continuing Education Programs in Mental Health.* G.P.O., Washington, D.C. 1971. 16 p.

These Guidelines were developed by an ad hoc advisory committee convened in April 1969 by the Continuing Education Branch, Division of Manpower and Training Programs, NIMH. They are probably the best short statement and set of rules in print, useful for all continuing educators, not just those in mental health. Three charts illustrate and provide general checklists for community involvement, education, and administration and finance. There is an excellent 36-item reference list on evaluation and evaluative-research. (RJB)

206. DEAN, Gary S. and others. *Regional Medical Program: Guidelines for Evaluation.* Univ. of Southern California. School of Medicine, Los Angeles, Cal. 1969. 24 p.

This set of guidelines was written to provide a systematic explanation of the process of evaluation applied to Regional Medical Programs. The first step in evaluation is the development of objectives–both immediate and long range. The second phase is the selection or design of measuring instruments or the design of other procedures to collect data that will lead to evidence for evaluation. Next comes the collection of data–from the health professional as a participant in a learning experience and as practitioner, and also from society. The fourth phase is analysis of the data; then judgment is made of how well objectives have been met. (A checklist is included; an appendix gives examples of decisions and modification.) (ERIC/PT)

207. HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION (DHEW). *National Conference and Workshop on Evaluation, 1970.* G.P.O., Washington, D.C. 1971. 235 p. Proceedings: Regional Medical Programs. DHEW Publication No. HSM-71-7010.

This conference and workshop, held in Chicago, September 28-30, 1970, was the first time that coordinators and staff members from all 55 RMPs met to discuss evaluation and to evaluate their own activities and programs. The proceedings of presentations, workshops and discussions cover many subjects other than evaluation, and their treatments of evaluation range all the way from an analytic model applicable to all management ("An Approach to Evaluation for the Regional Medical Program," by Donald A. Schon, President, Organization for Social and Technical Innovation) to concrete evaluations of medical care (coronary care, multiphasic screening, etc.) to concrete evaluations of aspects of continuing education. (RJB)

208. STEELE, Sara M. "Program Evaluation as an Administrative Concept." Paper developed for the American Educational Research Association Annual Meeting, New Orleans, La. Feb. 28, 1973.

A new type of evaluation, program evaluation, is beginning to take shape. Instructional objectives and institutional goals–the micro and macro levels–have emerged as specialized fields within the literature. More attention is beginning to be paid to hierarchies and networks of objectives and goals. Program evaluation should be considered in a managerial context, as opposed to merely an instructional or research context. "As a start" Steele offers the following definitions: "Program evaluation is the process by which criteria and evidence are used in forming judgments about programs, alternative programs, and alternatives within programs and within the programming system, as a means of facilitating key decisions about education." "Program evaluation is a process by which evidence, criteria and judgment are used in managing resources and facilitating accurate and appropriate decision-making in areas of major importance about education." Program evaluation is concerned with the extent to which the mission and institutional goals of the organization and of education are being met. This relating of the macro and micro levels–the relating of the parts to the wholes–should prove fruitful to thinking in which continuing education is used as a managerial strategy and continuing education is based upon demonstrated deficits in performance. (RJB)

209. LONG, Lillian D. "The Evaluation of Continuing Education Efforts". *American Journal of Public Health.* June 1969. Vol. 59, No. 6, pp. 967-973.

The author, director of Professional Examination Service of the American Public Health Association, finds in public health literature little evidence of efforts to measure the actual accomplishment of continuing education courses. She rejects the views that subjective evaluation is adequate, that evaluation is impossible, that it is unnecessary or irrelevant, and that the results of evaluation do not justify the time. She summarizes some major assumptions underlying the program of continuing education in public health (that manpower problems can be met to an important degree by retraining and updating programs; that new knowledge, new points of view, new orientation acquired in courses will be translated into improved attitudes and behavior which will, in turn enrich public health programs, etc.) and calls for a start to examine and test these assumptions. (RJB)

210 LEWIS, Charles E. and HASSANEIN, Ruth S. "Continuing Education–An Epidemiologic Evaluation". *New England Journal of Medicine.* Jan. 29, 1970. Vol. 282, pp. 254-259.

This reports the results of a ten-year study "on the utilization and evaluation of continuing education offered by the University of Kansas." Among the findings were: (1) During 1956-1965 57 percent of the 2,090 physicians practicing in Kansas participated in courses of continuing education offered by the State University; (2) half of the recorded courses were taken by 7 percent; (3) internists took the most courses, and participation in metropolitan areas was lowest; (4) unrelated to physician participation were class standing in medical school, maternal and perinatal death rates, and regional rates for certain operative procedures. The authors cite changes they deem necessary to make continuing medical education more effective: (1) Involve the physician actively in areas where he has been made aware of his deficiencies; (2) reorganize the pattern of medical practice to relieve the physician's pressure of practice and the cost of the education; (3) periodic

relicensing *might* be required but only after the first two changes have been made. In a letter "To the Editor" in the *Journal* April 9, 1970, Robert W. Christie, M.D., questioned both the criteria used in the study for determining the effectiveness of continuing medical education and one of the authors' conclusions. He said that "the most valuable means of carrying on continuing education is practical work," and that rather than rearranging the physician's practice, the continuing education programs should be rearranged. (RJB)

21. MATZICK, Kenneth J. *A National Survey to Evaluate Continuing Education in the Field of Hospital Administration.* Univ. of Iowa. Graduate Program in Hospital and Health Administration, Iowa City, Iowa. 1967. 91 p. Health Care Research Series Monograph No. 5.

The author surveyed more than 1,800 administrative personnel with a questionnaire to get their assessments of continuing education courses in hospital administration. They were asked to evaluate eight types of courses for effectiveness in terms of whether the information provided was current, practical, new, stimulating etc. The respondents ranked university-based executive development programs highest, they preferred seminars over lecture groups, and liked an equal mixture of specific and general information to be presented. More than 85 percent said there was a gap between new knowledge available and practice. (RJB)

1. CONTINUING EDUCATION OF HEALTH MANPOWER

1.11 Components of the Continuing Education Process
1.115 Hospital Libraries

2. ADULT AND CONTINUING EDUCATION
3. PREPARATORY EDUCATION
4. HEALTH-CARE SERVICES

212. MICHAEL, Max. "The Medical Library's Vital Role in Physicians' Continuing Education". *Hospital Progress.* Oct. 1968. pp. 92-98.

The author writes that despite the newer techniques for continuing education, the printed word remains the basic agent for the distribution and store of knowledge. He contends that since medical literature helps the physician keep up with medical advances, his personal library should be complemented by the hospital library. Frequently, however, the hospital library facilities are cramped, out-of-the-way, and open only during certain hours. In many hospitals, the responsibility for the medical library is given to the medical records librarian, who may have little or no interest in the library. Michael suggests that journal copies of more than 10 years should be removed, since they play an insignificant role in the physician's continuing education. His studies show that physicians frequently shun the hospital library because they don't know how to use it. He recommends that the library furnish bibliographies, help in planning conferences, and furnish abstracts. Finally, he argues that if the library is to be a vital link in the chain of continuing education for the physician, it must be adequately financed. (MAP)

213. ROBINOW, Beatrix H. *Organization of Hospital Libraries.* Canadian Hospital Association, Toronto, Canada. 1967. 96 p.

This outline offers a simple guide for non-professional librarians faced with building and running hospital libraries. Directed toward Canadian hospital libraries, it is useful also to American libraries. Topics include: organization and administration, selection and ordering, cataloguing, classification, reference work, circulation and loan procedures, library statistics, and book and periodical lists. The author concedes that this in only one manner of operation and suggests that the librarian consult other manuals it mentions. (MAP)

214. STEARNS, Norman S. and RATCLIFF, Wendy W. "An Integrated Health-Science Core Library for Physicians, Nurses and Allied Health Practitioners in Community Hospitals". *New England Journal of Medicine.* Dec. 31, 1970. pp. 1489-1498.

The Core Medical Library has been revised, updated and expanded in the hope of providing a single library facility for the entire health-care team. Items were included in the list on the basis of recommendations submitted by specialists in the pertinent fields. The expanded core collection costs about $4,000. Space requirements are about 40 linear feet for books, 90 feet for journals and 15 feet for reference tools. (RJB)

215. STEARNS, Norman S., BLOOMQUIST, Harold and RATCLIFF, Wendy W. "The Hospital Library–Part 1," and "The Hospital Library–Part 2". *Hospitals.* March 1, 1970 and March 16, 1970. Vol. 44.

These articles give guidelines for the development of total health science libraries in community hospitals, using the medical core collection as the base. They were written from the experience of the Postgraduate Medical Institute (PMI), the Massachusetts Medical Society, and the New England Regional Medical Library Service (NERML) in the development of library programs in 40 New England hospitals. (RJB)

216. DUNCAN, Howertine Farrell. "Selected Reference Aids for Small Medical Libraries". *Bulletin of the Medical Library Association.* April 1970. Vol. 58, No.2.

This is an annotated list of 179 items compiled as a guide to the development of the reference collection in a small medical library. Duncan revised lists previously published in 1959, 1962 and 1967. (RJB)

217. BRANDON, Alfred N. "Selected List of Books and Journals for the Small Medical Library". *Bulletin of the Medical Library Association.* April 1971. Vol. 59, No. 2.

This updated list of 389 books and 135 journals is intended to aid the selection for the small library of a hospital, medical society, clinic or similar organization. It is the fourth revised version of a paper originally published in the same magazine in July 1965. (RJB)

218. WEINSIEDER, B. Gail. "Cooperative Venture Proves Successful." *Hospitals.* Jan. 16, 1972. Vol. 46, No. 2. pp. 52-55.

The director of the Hospital Library Development Service, Charles A. Dana Medical Library, University of Vermont, describes the development and the

first year of operation of the program to improve hospital library services, first in Vermont, and then in Northern New England. The idea is to convert the "image" from repository to "Information Center," to get a "service-conscious" person employed at least half-time, to give basic training, to get the hospital familiar with various indexes (e.g., *Abridged Index Medicus*), to put out a core library on a four-month loan, to make Audiovisual equipment and materials available, and let the demonstration stand. "We ask for a proving time during which we try to supply many of the support services necessary, so that administrators will know what they are being asked to fund and, more precisely, how an Information Center can assist hospital personnel and improve patient care. Our experience thus far has convinced us that the product is good and, in fact, will sell itsself if people have a change to try it first." (RJB)

1. CONTINUING EDUCATION OF HEALTH MANPOWER

1.11 Components of the Continuing Education Process
1.116 Financing Continuing Education

2. ADULT AND CONTINUING EDUCATION
3. PREPARATORY EDUCATION
4. HEALTH-CARE SERVICES

219. AMERICAN HOSPITAL ASSOCIATION. *Financial Aid Programs in Support of Health Occupations: A Guide for Auxiliaries.* American Hospital Association, Chicago, Ill. 1971, 78 p.

This manual offers a step-by-step guide for setting up financial-aid programs for undergraduate, graduate, and continuing education students in all health occupations. Various methods are offered; scholarships, stipends, tuition refunds, etc. Appendices include annotated bibliographies on health occupations and financial aid, and a description of the College Scholarship Service. (MAP)

220. LEE, Barbara J. "Financial Support for Continuing Education". *Journal of Continuing Education in Nursing.* Sept./Oct. 1971. pp. 7-12.

This was an issue paper for the Third National Conference on Continuing Education in Nursing held at the University of Wisconsin, Madison, October 18-22, 1971. It examines sources of financial support for continuing education of professional nurses, reviews how financing patterns influence continuing education program content, and suggests ways nurses can influence financing mechanisms. (MAP)

221. LESSINGER, Leon M. and TYLER, Ralph W., Editors. *Accountability in Education.* Charles A. Jones Publishing Company, Worthington, Ohio. 1971. 85 p.

The literature on the financing of continuing education that has general significance is scarce. The approach to rational schemes for financing continuing education is clearly through the evolving issue of "accountability."

Accountability is the ability to know and explain clearly why resources should be committed and to know and explain clearly and honestly what the outcomes of the expenditures of resources have been. In the introductory chapter to this volume, Ralph Tyler writes: "Three recent developments appear to have influenced the current emphasis and concern with accountability: namely, the increasing proportion of the average family's income that is spent on taxes, the recognition that a considerable fraction of youth are failing to meet the standards of literacy now demanded for employment in civilian or military jobs, and the development of management procedures by industry and defense that have increased the effectiveness and efficiency of certain production organizations. These developments have occurred almost simultaneously, and each has focused public attention on the schools."

That paragraph is capable both of generalization and of adaptation to many fields. The increasing proportion of the average family's income spent on taxes and on other payments for essential services; the recognition that in field after field the outcomes of the expenditures are unsatisfactory; and the knowledge that managerial procedures for increasing effectiveness and efficiency exist—these developments affect all major fields of activities and all components within them.

Therefore this volume is included under "financing" because accountability is the only generally applicable rational approach to financing continuing education for health manpower. Although the chapters are all aimed at education and educators, their analyses are applicable to continuing education and continuing educators of health manpower.

The book concludes with a bibliography of 8 books and 130 periodical articles on accountability, many of which have general applicability, and this item is included as much for the bibliography as for its chapters. (RJB)

1. CONTINUING EDUCATION FOR HEALTH MANPOWER
2. ADULT AND CONTINUING EDUCATION

2.1 Adults, General

3. PREPARATORY EDUCATION
4. HEALTH-CARE SERVICES

222. PRESSEY, Sidney and KUHLEN, Raymond G. *Psychological Development Through the Life Span.* Harper, N.Y. 1957. 675 p.

Part one, "Abilities, tasks, and achievements," deals with organic potentials and major tasks. Part two, "Dynamic and social development," is concerned with motivation and emotion, values, and social relationships. Part three, "Preface to a 'life-span' psychology of the future," is an effort to make integrations and applications and to stress the most vital issues in the total volume. (ERIC)

223. KUHLEN, Raymond G. and others, Compilers. *Bibliography. Learning and Cognitive Performance in Adults.* Syracuse Univ. Adult Development Study, Syracuse, N.Y. 1967. 108 p.

This bibliography of over 1,500 items is largely devoted to various types of adult learning and cognitive behavior (conditioning, skill learning, discrimination, verbal learning, problem-solving and complex behavior, memory, verbal behavior, and set), to studies on intelligence and test behavior (age changes, correlational and factor analytic research, vocabulary, biological intelligence, psychomotor tests, and populations with organic and functional disorders), and to the effects of aging on perception. Also represented are studies of reaction time, achievement and productivity, and education and industrial training, together with psychophysiological research methodological problems in aging research, and books and literature reviews. (ERIC/LY)

224. SCHWARTZ, Milton M. and LANYON, Richard I. *Psychological Foundations of Adult Education.* Rutgers–The State Univ. Univ. Extension Division, New Brunswick, N.J. 1966. 17 p. Univ. Extension Bulletin, 5.

Two papers are included in this bulletin. The Schwartz paper, "Theories of motivation and their application to adult education," surveys the thinking, research, and conclusions of some of the leading figures concerned with social motivation. It attempts to classify these theories by generating a two-dimensional schema of social motivation. The horizontal continum includes positive-striving theories on one end and need-reduction views on the other. The vertical continum puts achievement motivation on one end and affiliation-comfort needs on the other. An attempt is made to demonstrate the utility of the schema through examples from statements of adult

education students. Lanyon, in "Psychological learning theory, application to adult education," reviews some of the major thinking of scholars in the field of animal learning (crucial factors of amount of practice and reinforcement), examines findings in the field of human verbal learning (added crucial factors of meaningfulness and organization of materials), and then summarizes applications of these principles to education. The teaching machine is described as making direct use of these important principles of learning and suggestions are made for application in regular classroom teaching. (ERIC/EB)

225. VERNER, Coolie and DAVISON, Catherine V. *Physiological Factors in Adult Learning and Instruction.* Florida State Univ. Dept. of Adult Education. Research Information Processing Center, Tallahassee, Fla. 1971. 26 p.

This monograph is one of a series developed by the Research Information Processing Center at Florida State University to identify, translate and interpret research and information relevant to significant problems in the field of adult basic education. It was written for the practitioner. The present and succeeding monographs in this bibliography are not, however, limited in their usefulness to the field of adult basic education. Fundamental findings regarding the physiology of adulthood and its bearing on learning are presented in short chapters on "the aging process," "vision," "hearing," "learning," and "performance," and are summarized in less than a page. Eleven references for additional study are recommended. (See the next item.). (RJB)

226. VERNER, Coolie and DAVISON, Catherine V. *Psychological Factors in Adult Learning and Instruction.* Florida State Univ. Dept. of Adult Education. Research Information Processing Center, Tallahassee, Fla. 1971 27 p.

This is a monograph supplementing the one by the same authors on physiological factors (listed above) in the same series. It too was written for the practitioner who wants to bring the results of research to bear upon problems of adult learning. The chapters are on "the stages and conditions of learning and instruction," "remembering and forgetting," and "designing and managing instruction." Eleven references for additional study are given. This and the preceeding monograph are available from the Adult Education Research Information Processing Center, 920 West College Ave., Tallahassee, Florida 32306. (RJB)

227. ERIC CLEARINGHOUSE ON ADULT EDUCATION. *Self-Concept in Adult Participation: Conference Report and Bibliography.* Syracuse Univ. ERIC Clearinghouse on Adult Education, Syracuse, N.Y. 1969. 63 p

These papers are the result of the Summer Adult Education Conference in July 1969 at the University of Wisconsin where 150 participants from across the country discussed the question: "How does the potential adult learner see himself as a person and does the answer to this question relate to the adult's search for continuing learning?" One paper discusses theories on behavior and motivation in the context of self-concept. Another stresses curiosity, enjoyment of learning activities, and pleasure in acquiring knowledge as reasons for participation in education. A third paper revolves around the ways in which conflicting psychological needs, role transition, and the attitude or

sense of powerlessness affect adult learning. The document also includes references to other ERIC/AE publications and additional relevant references, notes on availability, and the ERIC Document Reproduction Service order form. (MAP)

1. CONTINUING EDUCATION FOR HEALTH MANPOWER
2. ADULT AND CONTINUING EDUCATION

2.2 Adult and Continuing Education, General

3. PREPARATORY EDUCATION
4. HEALTH-CARE SERVICES

228. HOULE, Cyril O. *The Design of Education.* Jossey-Bass Inc., San Francisco, Cal. 1972. 323 p.

This book is an attempt to provide a model for designing not only all *adult* education activities but all *education* activities. It is based upon the examination of how adults learn and is reinforced by the findings of research on how children learn. It is new, coherent (not eclectic) and comprehensive. The system of "the design" is in two interrelated actions. The first action is to decide in what kind of situation the process of education is to occur: the second action is to apply to the situation a framework (or model) of planning or analysis. The situations are classified in eleven categories, broadly divided into those which occur on an individual, a group, and institutional, or a mass basis. The framework is made up of components, the four main groups of which are objectives, the elements of the format, the adjustments to fit the format into the milieu, and evaluation. This mechanical summary does not convey the flexibility of Houle's system or its happy marriage of theory and practice. Its comprehensiveness and novelty can be appreciated only after reading the first chapter, "Credos and Systems," which analyzes the growth of systematic thought in adult education, including the influences of John Dewey, Ralph Tyler and Kurt Lewin, and the long "Bibliographic Essay" at the end, which gives a critical appraisal of major writers in adult education and related fields, organized by approaches and theories. A glossary is presented in two forms—one a summary of the book's contents with key terms in context, and the other a listing with definitions. While the definitions are put forward only as the terms are used in the book, they should contribute to more precise usage in the field. This is the crowning achievement of a man who more than any other person has moved adult education toward professionalism. (RJB)

229. KNOWLES, Malcolm S. *The Modern Practice of Adult Education: Andragogy Versus Pedagogy.* The Association Press, N.Y. 1970. 384 p.

This book is an inquiry into the newly emerging technology of adult education based on an original theory of andragogy (the art and science of helping adults learn) as distinguished from pedagogy (teaching children and youth). Its central thesis is that adults in certain crucial respects are different from young people as learners, and that a different approach is needed. Part I explores what the differences are, and what they mean to the development of

a unique adult education methodology. In Part 2, principles and practical techniques are offered for establishing an organizational climate and structure, assessing needs and interests, defining purposes and objectives, translating objectives into program designs, organizing and administering local programs, evaluating them, and using a systems approach to program planning and operation. The third part presents tested management procedures for courses, workshops, institutes, and other types of educational activities. Numerous samples of actual programs and successfully used materials are introduced to illustrate a variety of curricular offerings, interest groups, and learning levels. (ERIC/LY)

230. BERGEVIN, Paul *A Philosophy for Adult Education.* The Seaburg Press, N.Y. 1967. 186 p

This book presents some ideas that constitute a supporting structure for an effective program of adult education in a free society. It begins with an overview of the adult, his society, and adult education, a discussion of goals and structure for adult education, and specific meanings of the term—as a systematically organized program, as random experiential learning, and as a field of study. Then follow two chapters on significant personal and social problems which may inhibit or misdirect the learning of adults. Twelve concepts to implement the education of adults are presented. A summary emphasizes the necessity of continuous learning in a free society. (ERIC/EB)

231. MILLER, Harry L. *Teaching and Learning in Adult Education.* Macmillan Co., N.Y. 1964. 345 p.

In this guide to learning and teaching in adult education, various educational principles, kinds of learning, and methods and techniques are examined. Chapters 1 and 2 survey basic learning processes, types of behavior change, educational aims and methods, and crucial conditions for learning (chiefly motivation, awareness of needs and goals, practice, and a sequence of appropriate materials). Concept attainment, problem-solving, and other significant kinds of behavior change are explained in the third chapter. Uses of small-group techniques in classrooms, residential programs, and informal group discussion are covered in the next three chapters. The remainder of the book discusses programmed instruction, correspondence study and other methods and resources for individual study, the role of television and other mass media in formal and informal adult education, and evaluation techniques and processes. (ERIC/LY)

232. GRABOWSKI, Stanley M., Editor *Adult Learning and Instruction.* Syracuse Univ. ERIC Clearinghouse on Adult Education, Syracuse, N.Y. 1970. 137 p.

These eight conference papers discuss adult learning, instructional theory and related issues in research and practice. Focusing on processes of educational change, the first paper considers how experienced teachers, educational theorists, and researchers possessing empirically tested knowledge can cooperate in program planning. The next paper reviews the adult instruction literature, then offers some generalizations, and closes with an exposition of the author's theory of instructional transactions or interactions. Another examines broad educational strategies in terms of social games—learned cultural sequences—which create communication networks conducive to

various kinds of learning. Next, adult educators are offered guidelines for competing more effectively for funds and program support. In another paper, Malcolm Knowles argues the importance of the emerging field of andragogy (the science of helping adults learn) and suggests implications for adult learning environments. The next two papers look toward a differential psychology of adult learning and adjustment potential, and indicate how adult educators might apply existing knowledge in motivating and working with adults and in choosing appropriate overall strategies. Finally, consideration is given to administrative responsibility for effective, relevant instruction. (ERIC/LY)

233. COLUMBIA UNIV. TEACHERS COLLEGE *Cogito – Knowledge and Action in Adult Education.* Columbia Univ. Teachers College, N.Y. April 1971.

This issue presents papers relating to using both knowledge and action in adult education programs. The titles and authors of the papers are as follows: "Toward a Theory of Practice in Adult Education" by Jack Mezirow; "Action Seminars" by Alan Knox; The Case-Study Approach–Alternation between Knowledge and Action in Adult Education: (a) "Prepare Case Materials" by Alan Knox, (b) "Franklin Community College .Continuing Education Division–Discussion Case" by Alan Knox, (c) "Analysis of Franklin Community College Case" by Howard Williams: "Opportunities for Careers in Adult and Continuing Education for Paraprofessionals and Volunteers" by Elmer Fleming and Alice Leppert; "Some of the Department's Students Describe Their Jobs" by Alice Jacobson and Bernard Gresh; "Maybe Later On–" by Bernard Gresh; and "Adaptation of Knox's Model of Continuing Professional Education Need Appraisal to Exchange Teachers" by Eitan Israeli. (ERIC/DB)

234. BLAKELY, Robert J. and LAPPIN, Ivan M. *Knowledge is Power to ol Power: New Institutional Arrangements and Organizational Patterns fo Continuing Education.* Syracuse Univ. Publications in Continuing Education, Syracuse, N.Y. 1969. 88 p.

This report is based on a study of new institutional arrangements and organizational patterns for continuing education in the United States during 1969. The study indicates a general trend in American society toward applying knowledge to solve social problems and a general trend in educational institutions to relate knowledge to social action. Specific movements in the use of continuing education by noneducational institutions are reported, along with its progress to a more central role in educational institutions. Developments in national continuing education associations are sketched, including both obstacles to cooperation and trends toward common interests. An approach to common ground is suggested. Ten steps to improve the field of continuing education are recommended. It is concluded that continuing education needs a stragegy for making a cumulative impact. (ERIC/LY)

235. COPELAND, Harlan G. and GRABOWSKI, Stanley M. "Research and Investigation in the United States". *Convergence.* 1971. Vol. 4, No. 4. pp. 23-30.

"In 1959, Brunner concluded that adult education research was in a chaotic situation. He found that with the exception of a few areas, such as adult

learning, there had been little attention given to research. Most of the research applicable to the problems of adult education, other than in the field of methods, was conducted by social scientists. Brunner saw major handicaps to research in adult education: the pressure of large enrollments, the newness of the profession, the profusion of agencies, a lack of funds, and an emphasis on descriptive studies. Eleven years later DeCrow observed: 'Each year the amount of (adult education) research increases; it will continue to increase; the annual production now, compared to (say) 10 years ago, is dramatically greater. The quality has unmistakably improved.... More competent researchers and more reports turn up from unexpected sources–correctional institutions, hospitals, social welfare agencies and many others.' Today, 15 years after the Brunner study, we can report that the improvement of both the quality and quantity of adult education research continues." The following are reviews, reports or bibliographies of research in adult education.

236. *Research and Investigation in Adult Education*, an annual register. From 1955 through 1967 it was compiled by voluntary editors and published in the summer issues of *Adult Education*, the professional quarterly of the Adult Education Association of the U.S.A. Since 1968 it is compiled by the ERIC Clearinghouse on Adult Education and published as a separate volume by the Adult Education Association of the U.S.A. The summer issues of *Adult Education* list pertinent surveys and recent publications in adult education.

237. BRUNNER, Edmund de S. and others. *An Overview of Adult Education Research.* Adult Education Association of the U.S.A. Chicago, Ill. 1959.

238. ESSERT, Paul L. "Adult Education–An Overview." *Review of Educational Research.* Vol. 23. June 1953.

239. HENDRICKSON, Andrew. "Adult Education." In *Encyclopedia of Educational Research.* (3rd ed.) Edited by Chester W. Harris. The Macmillan Company. New York, N.Y. 1960.

240. KREITLOW, Burton W. "Adult Education–An Overview." *Review of Educational Research.* Vol. 29. June 1959.

241. KREITLOW, Burton W. "Adult Education: Needed Research." *Review of Educational Research.* Vol. 35. June 1965.

242. KREITLOW, Burton W. "Research in Adult Education." *Handbook of Adult Education in the United States.* Edited by Malcolm S. Knowles. Adult Education Association of the U.S.A. Chicago, Ill. 1960.

243. KREITLOW, Burton W. "Research and Theory," *Handbook of Adult Education.* Edited by Robert M. Smith and others. The Macmillan Company, New York, N.Y. 1970.

244. KREITLOW, Burton W. *Educating the Adult Educator; Part 1. Concepts for the Curriculum.* Bulletin 573. U.S. Department of Agriculture. Washington, D.C. March 1965.

245. KREITLOW, Burton W. *Educating the Adult Educator: Part 2. Taxonomy of Needed Research.* Theoretical Paper No. 13. Center for Cognitive Learning. University of Wisconsin. Madison, Wisc. May 1968. (RJB)

1. CONTINUING EDUCATION FOR HEALTH MANPOWER
2. ADULT AND CONTINUING EDUCATION

2.3 Sponsorship of Programs

3. PREPARATORY EDUCATION
4. HEALTH-CARE SERVICES

246. SMITH, Robert . and others, Editors. *Handbook of Adult Education.* The Macmillan Company, N.Y. 1970. 594 p.

The 1970 edition of this handbook is an attempt to reflect the totality of adult education–its background, function, objectives, and roles as a discipline and in American society. It is divided into three parts. Part I discusses forms, functions, and the future of adult education–social setting and international dimension for adult education, program development and evaluation, information resources and services, technology, research and theory, philosophical consideration and adult educators. Part II contains papers on institutional forms and arrangements in adult education–colleges and universities, public schools, libraries and museums, cooperative extension service, armed forces, labor unions, business and industry, health and welfare agencies, religious institutions. The third part outlines program areas–curriculum and content, adult basic education, education for the family, social and public responsibilities, vocational and technical education, continuing and self-fulfillment education.

Persons interested in continuing education for health manpower should consult particularly "The Educators of Adults," by Cyril O. Houle, Chapter 7 (pp. 109-119); "Research and Theory," by Burton A. Kreitlow, Chapter 9 (137-149); "A Glance at the Future," by Paul A. Miller, Chapter 10 (151-167); "Adult Education Institutions," by William S. Griffith, Chapter 11 (171-189); "Colleges and Universities," by Kenneth Haygood, Chapter 12 (191-212); "Community Colleges," by Ervin L. Harlacher, Chapter 13 (213-229); "The Cooperative Extension Service," by Edgar J. Boone, Chapter 16 (265-281); "Health and Welfare Agencies," by Joe R. Hoffer, Chapter 20 (335-351); "Human Relations–Sensitivity Training," by George K. Gordon, Chapter 25 (425-438); "Vocational-Technical Education," by Grant Venn, Chapter 28, (473-486); "Continuing Education for the Professions," by Alexander N. Charters, Chapter 29 (487-498); and "Education for Self-Fulfillment," by Glenn Jensen, Chapter 31 (513-526). Most of these chapters have extensive bibliographies. Appendix I (pp. 529-547), is a Directory of Participating Organizations of the Coalition of Adult Education Organizations (CAEO). Appendix II (pp. 551-563) is General Information Sources in Adult Education, including adult education journals; current indexing and abstracting services; major retrospective, general bibliographies, literature guides and research reviews. (RJB)

247. MILLER, Paul A. *The Cooperative Extension Service: Paradoxical Servant–The Rural Precedent in Continuing Education.* Landmarks and New Horizons in Continuing Education, No. 2, Syracuse University Publications in Continuing Education. Syracuse, N.Y. 1973. 28 p.

Miller, now President of Rochester Institute of Technology, has seen the Cooperative Extension Service from many vantage points–both within and without, from being a product, to being vice president and president of two land-grant universities, to being an assistant Secretary of DHEW. The "paradox" is that the Cooperative Extension Service was so successful in dealing with the technological and economic side of extension, to the neglect of the human side of the from-rural-to-urban revolution, that its future is now cloudy and its role is not clear. It has often most benefited those least in need and least benefited those most in need. "Cooperative Extension would arrive at a crossroad of decision, unfortunately delayed. One choice led down the road to a more open casting of Cooperative Extension as adult education, toward a unique pattern for extending the knowledge and talent of the university to the people, and expanding from rural to urban problems. The other choice would have Cooperative Extension continue to view itself as a development organization for solving problems, to maintain its loyalty to commercial agriculture, to stress achievement of high levels of farm production efficiency, to strengthen the ties to specialized commodity associations." Miller traces CES' attempts to keep its familiar base, yet to broaden its clientele and services and support. He sketches three reports–the 1948 Joint Committee Report on Extension Programs, Policies and Goals; the Scope Report of 1958; and *A People and a Spirit*, released in November 1968. None of these three reports chose between a "more open casting" and "sticking to the old mainstay of agricultural production, together with marketing, forestry, and soil and water conservation." All tried to straddle the crossroads. Miller concludes with some observations concerning Cooperative Extension and a more general remark: "The foregoing remarks have aimed to summarize some of the basic principles upon which Cooperative Extension played its role in the rural technological revolution. While it is unlikely that these principles will form an analogy for improving urban life, they do send out a message: the need for a more stable yet adaptable organization–at once local and national – for urban development. Without this design, the public will not likely be drawn into a commitment of will which is strong enough to turn back the enveloping malaise of urban living. Without this design, the typical pattern may be large aims, eloquent oratory, quick starts, and...failure. What happened through informal education in rural America will not chart how best to develop community learning in urban America. What the experience does show, however (admitting the many failures on the human side of rural development), is that the task is possible." (RJB)

248. NATIONAL UNIVERSITY EXTENSION ASSOCIATION BOARD OF DIRECTORS. "Report of the View of the Future Committee". *Spectator*. June 1972. pp. 9-15.

This report, accepted by the association's board, expresses several "views" relevant to continuing education for health manpower: "The student of the future will be anyone engaged in learning in any location for any portion of his time as long as his activity results in some measurable accomplishment. Certificating and credentialing must, in the future, depend much less on the completion of a prescribed routine and much more on the evaluation of the end result." "Academic standards in the future will become less concerned with prescribed routines and more with the assessment of the end product." "Utilization of knowledge will, in the future, receive increasing emphasis in the university's scheme of things, and skills in the identification, adaption and

application of research results and knowledge resources will, in fact, be recognized by universities as requiring a high order of competence, meriting the full partnership in the reward system." (RTB)

249. KNOWLES, Malcolm S. *Higher Adult Education in the United States; The Current Picture, Trends and Issues.* American Council on Education; Committee on Higher Adult Education, Washington, D.C. 1969. 124 p.

This survey provides a guide for discussion and inquiry for administrators and faculty members of higher educational institutions, people in government who work in adult education, and citizens who are concerned with this area of educational service. Essentially, it is an analysis of the literature of higher adult education from 1960 through 1968, as documented by the ERIC Clearinghouse on Adult Education at Syracuse University. It starts with an attempt to place the field of adult education in perspective. Chapter 2 presents a synopsis of the historical roots and a broad picture of the current situation. Chapter 3 identifies some of the external and internal forces that seem to be pressing for change. Chapter 4 summarizes the trends discerned in the literature; and Chapter 5 isolates the national, state, and institutional issues that are revealed as concerns of adult educators in institutions of higher education. A selected bibliography, with abstracts, is included. (ERIC/SE)

250. NATIONAL ADVISORY COUNCIL ON EXTENSION AND CONTINUING EDUCATION. *Message from the President of the United States Transmitting the Fifth Annual Report of the National Advisory Council on Extension and Continuing Education.* G.P.O., Washington, D.C. 1971. 72 p.

This document, under transmittal letter from the President, contains the recommendations and findings of the National Advisory Council on Extension and Continuing Education with respect to Federal involvement in programs for adult education. Recommendations include: (1) The Administration should develop a mechanism at the Federal level to coordinate and possibly consolidate all existing programs that have as a major thrust the post-secondary continuing education of adult citizens; (2) the State governments should develop state-wide administrative agreements through the utilization of educational resources to implement effective and efficient programs in continuing education in cooperation with Federal agencies; (3) steps should be taken to expand the Federal and State roles in the administration of post-secondary programs for adults under Title I of the Higher Education Act of 1965. Appended is a report to the Council of activities conducted under Title I of the Higher Education Act of 1965. It is noted that in the face of severe budget restraints and rigorous re-examination of educational priorities, the Council finds that continuing education and community service needs of the nation have suffered irreparable damage. (ERIC/CK)

251. NATIONAL ADVISORY COUNCIL ON EXTENSION AND CONTINUING EDUCATION. *A Question of Stewardship: A Study of the Federal Role in Higher Continuing Education.* G.P.O., Washington, D.C. 1972. Sixth Annual Report. 116 p.

The role of the Federal Government in Continuing Higher education was studied in three stages: (1) An identification was made and a description

written of all those Federal programs that have a community service, extension or continuing education component that involves institutions of higher education; (2) a series of case studies was prepared on particular Federal programs which represented major areas of Federal support and (3) drawing on facts and information developed in the first two stages, a broad assessment was made of the Federal effort in extension, continuing education, and community service. The following activities are recommended: (1) to keep current the information assembled on the programs already identified and to record new program activities, (2) to establish more systematic liaison with other administrators of Office of Education programs, and (3) to study State plans, Title I projects, continuing education needs of women and prisoners, effects of Federal programs on intra- and inter-university relationships, and quality control and consumer protection in higher continuing education. (ERIC/CK)

252. BUSHNELL, David S. *Organizing for Change: New Priorities for Community Colleges.* McGraw-Hill Book Co., N.Y. 1973. 235 p.

253. GLEAZER, Edmund J., Jr. *A Forecast Study of Community Colleges.* McGraw-Hill Book Co., N.Y. 1973. 239 p.

These two books are products of "Project Focus"—financed by the W.K. Kellogg Foundation to make a nationwide study of the community college to determine where it is headed, how likely it is to reach its objectives and what alternative strategies ought to be considered. Representatives of key constituent groups were polled to determine their views on the long-range goals to be served. Discrepancies between the desired goals and the present situation were pinpointed. Social and economic trends likely to influence the future directions of the community and junior colleges during the 1970's were identified. And a set of strategies for systematically achieving greater harmony between goals and current practice were set forth. The two books are complex and heavily factual, of detailed use to administrators and faculty members of junior and community colleges and members of the Association of Junior and Community Colleges. They do not lend themselves to summary. However, some of the implications for continuing education can be noted.

Among the trends that Bushnell sees affecting junior and community colleges are: "Strengthened lifelong learning programs will require institutional commitments and appropriate staffing well beyond the current level." "Improved ways of articulating career and transfer programs will need to be adopted if loss of credit is to be avoided by those in career-oriented programs... Work-study programs, part-time enrollment, intermittent enrollment, and external degrees offer promising alternatives to traditional procedures."

The main point of Gleazer's constructively critical study is suggested by his epigraph: "The colleges are going to have to come down to earth, get rid of the hierarchy that sits up there and feels superior rather than seeing education as a tool to work with. Education is not something to separate and divide. It should be seen as an everyday tool. There should be ways to integrate the tools of education into the community. The college should be here, with the poor in the rural and migrant community." (RJB)

254. TOUGH, Allen. *The Adult's Learning Projects: A Fresh Approach to Theory and Practice in Adult Learning.* The Ontario Institute for Studies in Education, Toronto, Ontario, Canada. 1971. 199 p.

The central focus is on the adult's efforts to learn, in particular, his decisions, preparations, reasons for learning, problems, and needs for help. The 15 chapters discuss: highly deliberate efforts to learn; episodes and learning projects; whether learning projects are common and important; what people learn; why people learn; preparatory steps in deciding to proceed with a learning project; choosing the planner; how common and important each type of planner may be; self-planned learning; improving self-planned learning; when a non-human resource serves as planner; learning projects planned by a person in a one-to-one relationship; a group or its leader as planner; practical implications for institutions and instructors; and what needs to be done. Three appendices present some borderline cases in defining learning projects; influential factors; and freedom, autonomy, and control. The book has 119 references. (ERIC/DB)

255. THOMSON, Frances Coombs, Editor. *New York Times. Guide to Continuing Education in America.* New York Times Book Publishing Co., N.Y. 1972. 850 p.

This is a guide, prepared by the College Entrance Examination Board, to the universities, colleges, community colleges, junior colleges, hospitals, technical schools, vocational schools and trade schools where adults can continue their education. It covers 2,281 schools in all 50 states and more than 50,000 courses for adults. It has a section on correspondence schools, a glossary, and a listing of national organizations active in continuing education. (RJB)

1. CONTINUING EDUCATION FOR HEALTH MANPOWER
2. ADULT AND CONTINUING EDUCATION

2.4 Goals
2.41 Work Goals

3. PREPARATORY EDUCATION
4. HEALTH-CARE SERVICES

256. SHATZ, Eunice O and LOWERY, Patti L. *New Careers: Generic Issues in the Human Services.* National Institute for New Careers, University Research Corporation, Washington, D.C. 1970. 219 p.

This is a revision of *Generic Issues in the Human Services: A Sourcebook for Trainers* (1968). The authors define generic issues as "fundamental social science concepts common to all human services" (e.g., the individual's relationships to work, to people, to the community). This book is directed toward trainers and supervisors responsible for the generic-issues component of a New Careers program, in which learning is linked with on-the-job experience. The subject matter and methodology described here are suitable

for use with entry-level trainees who have basic educational skills and at least fourth-grade reading ability. Besides discussions of the generic issues in New Careers, the contents include outlines for planning, organizing, and negotiating training, and curriculum development. (MAP)

257. NATIONAL MANPOWER POLICY TASK FORCE. *Conference on Upgrading and New Careers.* National Manpower Policy Task Force, Washington, D.C. 1970. 125 p.

This conference, held in Washington, D.C., March 20, 1970, was sponsored by the National Manpower Policy Task Force. Among the papers presented were: "Technical Support for Building Job and Educational Ladders," by Eleanor Gilpatrick; "Upgrading Issues and Policies for the Seventies," by Samuel B. Marks; and "Upgrading and New Careers in Health," by Sumner M. Rosen. (MAP)

258. PEARL, Arthur and RIESSMAN, Frank. *New Careers for the Poor, The Nonprofessional in Human Service.* Free Press, N.Y. 1966. 281. p.

Principally concerned with the indigenous nonprofessional working in economically disadvantaged communities, the first part of this book critically evaluates means of overcoming poverty and attempts to provide a feasible alternative through a far-reaching development of new careers for the poor based on the creation of large numbers of nonprofessional positions in the human service areas. The particular importance of these new positions in the field of education is stressed and a specific proposal is outlined utilizing education as a model. Chapters 5-7 are concerned with the employment of nonprofessionals in the mental health, research, and welfare spheres, and some illustrations of their functioning in these fields are provided. Chapter 8 is devoted to the training of the nonprofessional. Chapters 9-11 are a consideration of issues involved in utilizing this new type of personnel and the allies who are likely to support the new career movement. (ERIC/AJ)

259. NATTRESS, Leroy William, Jr., Editor. *Continuing Education for the Professions.* Natresources, Inc., Chicago, Ill. 1970. 151 p. (Proceedings of the Sections on Continuing Education for the Professions at the Galaxy Conference on Adult Education, Washington, D.C. December 8-10, 1969)

The qualifications for continuing professional education are spelled out. Then the efforts of the conference speakers and discussants are divided into seven major categories of testing the criteria of a model for the viability of a profession. The categories included: continuing professional education as a profession, models to define and explore problems, established facts and basic science, new ideas, continuing education and development of new occupations, economic and financial considerations, and the role of the consumer. (ERIC/Author)

260. FARMER, James A., Jr. and WILLIAMS, Robert G. "An Educational Strategy for Professional Career Change". *Adult Leadership.* April 1971. pp. 318-19; 355.

The authors use labor statistics to show that an ever-increasing number of professionals in their 30's, 40's and even 50's are voluntarily or of necessity, engaging in the career-changing process. Farmer and Williams suggest that

adult educators in a wide variety of institutions can make this transition easier. They offer Burkett's Career Change Educational Model for a Professional, emphasizing that career change is heavily dependent upon counseling. (MAP)

261. CLESS, Elizabeth L. "Social Change and Professional Continuing Educators", *Adult Leadership*. Feb. 1972. pp. 273-274, 299.

This article deals with the current search within the field of continuing education to find new professional personnel who are capable of coping with the shifting educational patterns of the future. (ERIC/Author/LF)

262. ERIC CLEARINGHOUSE ON ADULT EDUCATION. *Continuing Education in the Professions*. Syracuse Univ. ERIC Clearinghouse on Adult Education, Syracuse, N.Y. 1967. 14 p.

An annotated bibliography contains 21 indexed entries, mostly with abstracts, on such aspects of professional continuing education as medicine, law, management development, theological education and pastoral counseling, vocational counseling, social work, and extension work, together with participation, motivation, educational needs, educational methods and media, and career opportunities for college trained women. (ERIC/LY)

263. D'ANTONI, Susan, Compiler. *Continuing Education in the Professions: A Selected Bibliography*. Ontario Institute for Studies in Education. Dept. of Adult Education, Toronto, Canada. 1970. 19 p.

A list of works dealing with adult education in professional fields is given. One hundred and fifty citations are listed. Ordering information for documents cited is also provided. (ERIC/CK)

264. AMERICAN SOCIETY FOR ENGINEERING EDUCATION. "Goals of Engineering Education: Final Report of the Goals Committee." *Engineering Education*. Jan. 1968. pp. 370-476.

"It is clear that now and in the future, basic engineering cannot presume to teach students all they need to know. Accordingly, the profession and academic institutions which serve it must look forward to a growing activity in continuing engineering studies as a distinct educational function outside of advanced degree programs. This is not merely a matter of dealing with current obsolescence, retreading, retraining or any of the other popularized versions which have been developed, sometimes almost frantically, to satisfy urgent localized needs. It is rather a matter of establishing an entirely new dimension of personal development throughout the engineer's career. It is a matter of taking a long-range look at the ever increasing rate of technological change, and then deciding what now needs to be done to assure the continuing effectiveness of the profession in the 1970s and beyond. In this sense, the limited activity in educational institutions, even in recent years, under the broad title of continuing education cannot be considered as adequate for the need and service that is being considered today." (RJB)

265. STONE, Elizabeth W., Editor. "Personnel Development and Continuing Education in Libraries". *Library Trends.* July 1971.

This issue devoted four chapters to the continuing education of librarians: the first presents a model for a program of continuing education or personnel development to facilitate the application of management techniques; the second by Mary V. Gaver, "Continuing Education to Meet the Personalized Criteria of Librarians" discusses the exploratory strategy for self-learning as an effective method for producing the greatest change in knowledge and attitudes; the third by John F. Harvey and Bettina Lambert, "Programs for Continuing Library Education" examines problems of postgraduate education and suggest solutions; and the fourth chapter by Peter Hiatt, "Toward the Development of a National Program of Continuing Education for Library Personnel," discusses the current "system" of continuing education for library personnel and gives his reasons why a national program of continuing education is necessary. (MAP)

266. PUSEY, Nathan M. and TAYLOR, Charles L. *Ministers for Tomorrow.* The Seabury Press, N.Y. 1967. 147 p.

"We express one particular concern that the education of ministers after ordination be of different type from that now characteristic of the B.D. course. It should not be purely intellectual nor pedantic but take into large account the work of the minister in his particular station and the experience he has had of human hungers and theology's relation to life, and what he has learned in prayer and worship about the deep places of his own and others' innermost hearts. We do not separate intellectual stimulation and spiritual growth. Both are needed. We are concerned for the former, but the non-cerebral factors in education must not be omitted. The Church has an obligation to feed the intellectual fires it has kindled. It must also help a man to grow in the knowledge of what sort of a person he ought to be, and in the ability to practice that which he ought to do." (RJB)

267. HOFRENNING, James B., Editor. *The Continuing Quest: Opportunities, Resources and Programs in Post-Seminary Education.* Augsburg Pub. House, Minneapolis, Minn. 1970. 154 p.

The essays in this volume analyse the needs of the pastor for continuing systematic learning and describe some of the many opportunities available. The first part of the book deals with the situation of the pastor attempting to understand himself as a person and as a clergyman and shows the rewards of a continuing education program for the congregation as well as for the pastor. It relates theological education and personal faith. The second part opens up the possibilities for full or part-time professional education, describing specific areas of specialization. To conclude, there is a discussion of the ministry as a continuing process adaptable to humans in society at large. (ERIC/MD)

268. HABER, David and COHEN, Julius. *The Law School of Tomorrow.* Rutgers University Press, New Brunswick, N.J. 1968. 240 p.

"There has been a great effort to promote the continuing legal education of lawyers during the past twenty years. Efforts in this direction have gone on much longer than that in certain localities, particularly in some of the larger

states and cities; but by and large, nationwide, very little attention has been given to bringing lawyers in practice up to date, particularly the sole practitioner who needs it most.

"State administrators of continuing legal education have been appointed in all but nineteen states. Only a few had existed earlier. Much more needs to be done to develop their activities more fully and to raise and maintain the quality of the continuing legal education offered, and to persuade lawyers far more generally to make use of it. Much needs to be done to coordinate continuing legal activities throughout the nation, to make them more efficient and to improve the quality. The instruction should not be limited to how-to-do-it courses for practicing lawyers. There ought to be more emphasis on high level courses and on professional responsibility." (RJB)

1. CONTINUING EDUCATION FOR HEALTH MANPOWER
2. ADULT AND CONTINUING EDUCATION

2.4 Goals
2.42 Other Goals

3. PREPARATORY EDUCATION
4. HEALTH-CARE SERVICES

269. WHIPPLE, James B. and others. *Liberal Education Reconsidered; Reflections on Continuing Education for Contemporary Man.* Syracuse Univ. Publications in Continuing Education, Syracuse, N.Y. 1969. 117 p.

These four essays are the final papers of staff members of the Center for the Study of Liberal Education for Adults; their theme is that liberal education embodies a concern for man rather than things. James B. Whipple proposes a concept of "relational education," which aims to help the professional person relate his career to the rest of human life. Kenneth Haygood concludes that urban education has far to go before it will be ready to deal with man, since most efforts are still being directed at solving mechanical problems. Thus he sees the main task of future liberal adult education as providing men with the opportunity to become humane in an anti-humane community. Freda Goldman's goal for liberal education is to give direction to man's long-range leisure activities. She maintains that affluent contemporary man is as much a man of leisure as a working man, and suggests that we further develop the concept of occupations of leisure which provide serious avocations. Peter E. Siegle states that a thing-oriented education is an obsolete concept. Seeing modern man as a product of knowledge, technology, and the problems these have brought, he views the goal of education as helping people acquire personal attributes that form the basis of continued learning throughout life. (ERIC/SE)

270. EASTERN NEW MEXICO UNIV. *Adult Basic Education in New Mexico: Personal Growth Curriculum.* Eastern New Mexico Univ., Portales, N.M. 1970. 166 p. Results of Workshop held June 10-14, 1968 at Roswell campus of Eastern New Mexico University.

A workbook for use by teachers in adult basic education classes concerned with personal growth, this text covers five areas: Money Management, World

of Work, Citizenship and Government, Health Education, and Family Life. Each area is presented as to the course objectives, and units of instruction are given. It is suggested that approximately 50 percent of the classroom time be spent on the personal-growth curriculum. (ERIC/DB)

271. FELDMAN, Jacob J. *The Dissemination of Health Information, A Case Study in Adult Learning.* Aldine Pub. Co., Chicago, Ill. 1966. 288 p. NORC Monographs in Social Research, No. 11.

During the summer of 1955, the National Opinion Research Center conducted a nationwide health information survey of randomly selected and stratified samples of the general public, physicians, and pharmacists as part of a research program focusing on the patterns of medical care use then prevalent in the United States. This monograph is based on the results of that survey, supplemented by findings of more recent investigations, and treats the acquisition of health information as an aspect of adult learning. Chapters cover (1) research design and descriptions of sampling procedures and questionnaires, (2) the gap between medical practices in the United States and what is desirable, estimates of the level of utilization of medical care, and comparisons with levels during earlier periods and in other countries, (3) beliefs that facilitate the early detection and treatment of chronic illness, the extent to which medicine and physicians are respected throughout the population, and the public's satisfaction with medical care, (4) group differences in levels of health information and information sources, and (5) the general problems of information dissemination as they apply to survey results. (ERIC/AJ)

272. MARTIN, Mike. "Private Physicians Join in Public Program". *Occupations.* Dec. 1971. pp. 27-29.

Martin reports that a county-by-county survey of the United States by the Office of Economic Opportunity shows that only one out of seven low-income rural women needing family-planning assistance actually receives it. In 1970 the OEO set up demonstration programs in the sparsely populated regions of West Central Texas and Penobscot County, Maine, in which women are transported to the offices of private physicians for examination and treatment and are later visited periodically by outreach workers. The author thinks that rural women are well served by visits to private physicians; furthermore, planners of family-assistance programs saved the cost of hiring publicly paid medical personnel and of constructing new clinics. Potential problems posed by suspicions, ignorance, and resistance to "government handouts" were eased by employing only local residents for staff positions and outreach surveys. A big advantage of this private physician-family planning project is that it gets poor people into a health-care delivery system. (MAP)

273. SCIENTIFIC AMERICAN. "Science and the Citizen: Survival Kit". *Scientific American.* August 1972. pp. 45-46.

This describes a plan now under study at several medical-research facilities to make available to identifiable "coronary-prone" individuals a "survival kit" containing the tools for automatically self-injecting drugs capable of

suppressing the irregularities in cardiac rhythm that accompany acute heart attacks. The heart-attack victim uses a "CardioBeeper" to transmit the rate and rhythm to his physician or to a central emergency cardiac service. The physician can tell the patient to self-administer an appropriate treatment, which can greatly lessen the chances of death on route to the hospital. The basic idea came from Stanley J. Sarnoff, a former surgeon, medical-school professor and director of research in the Laboratory of Cardiovascular Physiology at the National Institutes of Health; Sarnoff is now president of Survival Technology, Inc., a Bethesda, Md. company engaged in the development of new medical devices. (MAP)

274. STOLL, Frances A. and CATHERMAN, Joan L. *Dental Health Education*, Fourth edition. Lea & Febiger, Philadelphia, Pa. 1972. 160 p.

The purpose of this fourth edition is to enhance the effectiveness of instruction of dental health concepts. It can be used by students and teachers for dental hygience, clinical practice, and office management. It will also be useful for public health educators, for in addition to new information on dental health insurance plans, incremental dental treatment for children, and reports and statistics about community health programs, it has an extensive list of selected readings in recent dental research literature. (JADA)

275. DOBERENZ, Alexander R. and TAYLOR, N. Burwell G., Editors. *Population Growth: Family Planning Programs.* Univ. of Wisconsin, Green Bay. College of Human Biology, Green Bay, Wisc. 1971. 177 p. Proceedings of the Annual Population Symposium at the Univ. of Wisconsin, Green Bay, Jan. 8-9, 1971.

These proceedings of the second annual symposium on population growth bring together speeches and panel discussions on family planning programs. Titles of speeches delivered are: Communicating Family Planning (Mrs. Jean Hutchinson); Effects of New York's Abortion Law Change (Dr. Walter Rogers); The Law and Birth Control, Sterilization and Abortion (Mrs. Harriet F. Pilpel); International Postpartum Program for Family Planning (Dr. Frank Shubeck); Consequences of Family Planning for Man's Genetic Future (Dr. James Crow); The Psychology of Family Size Desires (Dr. Edward Pohlman); and, Hospital Based Family Planning Services in an Urban Setting (Dr. Hugh Davis). The two panel discussions focus on a broad spectrum of related issues that were initiated by the audience. Among them are: insurance payments for voluntary sterilization; use of paramedical personnel in family planning services; religious, personal, and social attitudes which inhibit the adoption of family planning practices; legal issues; and promiscuity and venereal desease, etc. A list of books and articles on various aspects of family planning conclude the report. (ERIC/JLB)

276. PASSETT, Barry A. *Leadership Development for Public Service.* Gulf Publishing Co., Houston, Tex. 1971. 145 p.

The third in a series of books on human potential, the focus of this book is the leadership and management capability of people in public service. The chapters of the book are: (1) The Leadership Gap; (2) The Leader: Definitions; (3) The Issue Develops; (4) Creative Pressures for the '70s; (5) The Private-Public Dialogue; (6) Response: The Universities; (7) Response:

Training Outside the Universities; (8) Response: Government Training Initiatives; (9) Empty Credentials and New Careers; (10) The Training Argument; and(11)Leadership Development in the '70s. Aspects of the debate in the U.S. Senate on S. 11, the Intergovernmental Personnel Act, on October 27, 1969, are presented in the book's appendix. A nine and one-half page annotated bibliography presents lists of books, articles and reports. (ERIC/DB)

277. HOULE, Cyril O. *The Effective Board.* Association Press, N.Y. 1960. 167 p.

Houle defines a board as "an organized group of people collectively controlling and assisting an agency or association which is usually administered by a qualified executive and staff." The book is directed to those interested in boards in general and to those involved on a specific board. Valuable for agency or association members intetested in examining and reevaluating and improving their boards. Convenient appendix lists important criteria for the effective board and refers the reader to practical discussion of each criterion within the book. (MAP)

278. SHINER, Patricia and others. *Community Development in Urban Areas: A Summary of Pertinent Journal Articles and Book Chapters.* Missouri Univ. School of Social and Community Service, Columbia, Mo. 1969. 81 p.

Citations and abstracts for 78 articles and book chapters on urban community development, in both developed and developing nations, are included in this booklet. Emphases include encouraging the participation of the poor in community development programs; political aspects of urban community development; community structure; theories of planned change; the role of social workers and other personnel; and the description of various urban programs. (ERIC/MF)

279. WHIPPLE, James B. *Community Service and Continuing Education: Literature Review.* ERIC Clearinghouse on Adult Education, Syracuse Univ., Syracuse, N.Y. 1970. 81 p.

This review was undertaken to explore and analyze the literature in the ERIC Clearinghouse on Adult Education in terms of three important questions about Title I of the Higher Education Act of 1965. First, what is the relationship between community service and continuing education as revealed in the substance, audience, and methods of Title I programs? Second, to what extent are institutions of higher education responsible for community service and what is their role? Finally, what are the essential ingredients for an effective statewide system of community service and continuing education? Trends are suggested as well as areas in which universities appear to be standing still. An appendix with additional references to professional development, community development, and other forms of service is also included, along with 92 abstracts. (ERIC/LY)

1. CONTINUING EDUCATION FOR HEALTH MANPOWER
2. ADULT AND CONTINUING EDUCATION

2.5 Compcnents of the Continuing Education Process

3. PREPARATORY EDUCATION
4. HEALTH-CARE SERVICES

280. TYE, Norwood Burl *Process Guidelines for Adult Education Program Development.* Columbia Univ., N.Y. 1966. 277 p.

Process guidelines for adult education program development were identified by means of a detailed search of selected literature. Definition of the program development process includes (1) selection of educational objeetives, (2) selecting and organizing learning experiences to achieve objectives, and (3) evaluation. Publications since 1950 were selected based upon the criteria of general excellence, authority of the writer, pertinence, and timeliness. The four types of evidence used for support of guidelines in order of their value for the study were findings of research, statements of educational authorities, reports of experience, and untested opinions of authors. It was found that the three component parts of program development were interlocking parts of one whole process. The large number of guidelines identified in the study were hierarchically arranged under the six major headings of (1) selecting objectives, (2) relationship of objectives to learning experiences, (3) selecting and organizing learning experiences, (4) evaluation of the extent to which objectives have been achieved, (5) the relationship of selecting objectives to evaluation, and (6) the relationship of selecting and organizing learning experiences to evaluation. (ERIC/Author/PT)

228. HOULE, Cyril O. *The Design of Education.* Jossey-Bass, Inc., San Francisco, Cal. 1972. 323 p. See Item numbered for annotation.

281. McMAHON, Ernest E. *Needs-of People and Their Communities-and the Adult Educator: A Review of the Literature of Need Determination.* Syracuse Univ. ERIC Clearinghouse on Adult Education, Syracuse, N.Y. 1970. 86 p.

Focusing on eommunity education and development, this literature review analyzes the problem of determining community and individual needs; the issue of relevance to the community; the meaning of need (as opposed to interests or desires); and the use of community studies, listening posts, surveys, and power strueture analysis as evaluation tools. The issue of relevanee in particular is examined with respect to teaching versus action, disciplines versus the interdisciplinary approach, static programs, and the setting of program objectives. An 88 item annotated bibliography touches on adult basic education, vocational education, rural development, social change, professional continuing education, training design, participation, and other pertinent concerns. (ERIC/LY)

282. IVERSON, Robert W. *Midsim: The Maxwell International Development Simulation.* Syraeuse Univ. Continuing Education Center for the Public Service, Syracuse, N.Y. 1971. 160 p.

The Maxwell International Development Simulation (MIDSIM) was designed to provide continuity and a realistic laboratory for a series of month-long seminars conducted by Syracuse University for Midcareer officials from the Agency for International Development. The seminars were designed to provide learning in three broad areas: Policy and Issues, Interpersonal and Intercultural Relations, and Managerial Skills. The first four days of every week are occupied with academic presentations in these areas. Friday is reserved as game day--the opportunity to integrate and test the knowledge and skills acquired during the week. The three rounds of the game are played in two simulated environments: Washington and "the field" (a simulated country called Nanesa), each game being concerned with one of the three critical aspects of Agency activity: Policy Formation and Budgeting, Program Planning and Negotiation, and Project Implementation and Evaluation. Each of the games is discussed as to Game Preparation, Game Plan, Critique, and Game Materials. Charts are given of the Maxwell International Development Seminar and The U.S. Foreign Assistance Process. Diagrams present Space Requirements for MIDSIM I, MIDSIM II, and MIDSIM III. (ERIC/Author/DB)

283. ROSEN, Earl, Compiler. *Educational Television.* Canadian Association for Adult Education, Toronto, Ontario, Canada. 1969. 99 p. Special issue of *Trends.* (Toronto)

Based on extensive investigation, this special journal issue deals with educational television (ETV), including closed circuit television. It concentrates on examining and evaluating the state of the art of ETV, various forms of ETV (public television, formal and informal adult education, university credit courses, adult basic education, English as a second language, medical education) in Canada and elsewhere; examples of how closed circuit television is used and evaluated in universities; and televised teacher training at Stanford University and the University of Toronto. Also included are 32 references, an annotated bibliography, and a tentative definition of educational television. (ERIC/LY)

284. GRABOWSKI, Stanley M. "The Telephone as an Instructional Method in Adult Education". *Adult Leadership.* Sept. 1972. pp. 105-107.

After discussing "several technological advances" in the past few years that have made the telephone a more flexible means of instruction in adult education and citing conclusions concerning the conditions for its effective use, the Director of ERIC Adult Education lists 13 documents dealing with various aspects of instruction by telephone. (RJB)

285. GRABOWSKI, Stanley M. "Role of the Computer in Adult Education". *Adult Leadership.* Nov. 1972. pp. 178-179.

The Director of ERIC Adult Education cites the advantages of computer-assisted, or computer-aided instruction (CAI)--variously called also computer-based instruction (CBI), computer-assisted learning (CAL), computer-augmented education (CAE) and computer-managed instruction (CMI)--and then comments: "At present, there is no widespread use of computers in adult instruction." He then lists eight references to documents dealing with various aspects of CAI. (RJB)

286. WEDEMEYER, Charles A. *Evaluation of Continuing Education Programs.* Wisconsin Univ. Univ. Extension, Madison, Wisc. 1969. 11 p.

Evaluation in continuing education must be continuous, not a one-shot process. Steps in evaluating include: Preparing goals and objectives, selecting starting points appropriate to the clients, determining programs and attitudes, measuring progress, interpreting evidence of progress, and then using the evaluation to help students by providing guidance and motivation and helping teachers to clarify objectives and plan instruction. Evaluation programs are not used widely for several reasons: (1) Evalaution is still not perceived as a necessary part of the professional activities of program developers: (2) program developers regard it as of lower priority than their other activities: (3) it commands little financial support; (4) program developers often feel they are incompetent to carry out evaluation; (5) evaluation is threatening to some program developers; and (6) a truly professional education climate may not exist in the program development unit. (ERIC/JK)

287. STEELE, Sara M. *Contemporary Evaluation: Models and Their Implications for Evaluating Programs for the Disadvantaged.* ERIC Clearinghouse on Adult Education. Syracuse, N.Y. 1973.

This document was contracted by the ERIC Clearinghouse on Adult Education for use by persons working with "less advantaged" adults, but it would be useful to all continuing educators. Indeed, the conception of "evaluation" is so comprehensive that it would be useful to all executives who use training and education as a managerial strategy. The publication is probably the most complete survey and exposition of thinking about evaluation, historically and up to date. The first part explores the nature of changing ideas about evaluation, presents an overview of some of the old and new models of evaluation, and makes suggestions about the kinds of evaluation models and evaluative activities needed today. The second, longer, section, is an encyclopedia of references to more than 20 models.

This publication is only one of more than 70 of ERIC/AE's publications of various kinds--literature reviews, abstracts, basic information sources, bibliographies, etc.--that ERIC/AE has had produced and has published. A list of publications may be received by writing ERIC Clearinghouse on Adult Education, 107 Roney Lane, Syracuse, N.Y. 13210. (RJB)

288. STEELE, Sara M. *Cost-Benefit Analysis and the Adult Educator: A Literature Review.* Syracuse Univ. ERIC Clearinghouse on Adult Education, Syracuse, N.Y. 1971. 28 p.

This discusses the basic concepts of cost-benefit analysis and explores how they can be applied to adult education. The author finds that thus far use has been limited to programs which lend themselves to achieving economic outputs and programs which are closely associated with industry. She concludes that, while cost-benefit analysis can be used in adult education, input-output analysis is more flexible in dealing with the human variables of the educational system. An annotated bibliography is included. (MAP)

289. PHILLIPS, Louis E., Editor. *The Continuing Education Unit: A Compilation of Selected Readings.* Univ. of Georgia, Athens, Ga. 1972.

The "CEU"—the continuing education unit—is a measurement of noncredit continuing education activities that is becoming established in the United States. Early in 1968 the U.S. Civil Service Commission, U.S. Office of Education, the American Association of Collegiate Registrars and Admission Officers, and the National University Extension Association sponsored a national planning conference to study the feasibility of defining a uniform unit of measuring noncredit continuing education activities. A National Task Force was created, which in October 1970 published an interim statement with the definition: "One c.e. unit is ten contact hours of participation in an organized continuing education experience under responsible sponsorship, capable direction and qualified instruction." Application of the c.e. unit, the Task Force said, would systematize the recording and reporting system for participation in noncredit continuing education and "encourage long-range educational goals and lifelong learning as a process of continuing education."

Since then an increasing number of schools have adopted the "CEU", including the Southern Association of Colleges and Schools, the University of Florida, and the University System of Georgia. The University of Georgia Center for Continuing Education in Athens compiled this booklet of selected readings describing and discussing the concept, including writings by Keith E. Glancy of the Johns Hopkins University, Paul J. Grogan of the University of Wisconsin, and Grove J. Andrews of the Southern Association of Colleges and Schools. It is available for $2.00 from Louis E. Phillips, Director, University Evening Classes, Georgia Center for Continuing Education, University of Georgia, Athens, Ga. 30601. (RJB)

1. CONTINUING EDUCATION FOR HEALTH MANPOWER
2. ADULT AND CONTINUING EDUCATION
3. PREPARATORY EDUCATION

3.1 Primary and Secondary Education

4. HEALTH-CARE SERVICES

290. BUSH, Donald O. and others. *The World of Work and Learning.* Rocky Mountain Educational Lab., Inc., Greeley Colo. 1969. 24 p.

This position paper presents guidelines for an approach to career planning which integrates educational experiences with the world of work and job requirements, based on models developed in 1968 for the purpose of planning the "Image of the World of Work" program. It provides the rationale and the application of the models for general work-production and presents a guide for planning, work process, and evaluation. The three components of the occupational education program are: (1) "The Image of the World of Work," designed to help teachers emphasize work-relevant attitudes and occupational information throughout a student's total school experience, (2) The Occupational Clusters Curriculum, designed to create and test a scheme for the development of occupational education curriculums based on a career cluster concept at secondary school level, and (3) Cooperative Career Planning, a concept which stresses coordination of all relevant community resources so that all individuals might have the opportunity for job entry, continuous education, and upward occupational mobility. (ERIC/CH)

291. AMERICAN MEDICAL ASSOCIATION. *Horizons Unlimited.* American Medical Association, Chicago, Ill. 1966. 134 p.

This handbook, aimed primarily at high school and beginning college students, describes career opportunities in medicine and allied fields. Part One deals exclusively with medicine as a career-medical school selection, application and financing. Part Two covers career opportunities in eight major allied fields – rehabilitation, medical social work, medical technology, radiologic technology, nursing, hospital administration, dietetics and nutrition, and medical office work. Additional sources of information and reading lists are included. (MAP)

292. COLGAN, Francis E. and others. *Health Occupations Curriculum Development: In Search of A More Powerful Curriculum.* Rocky Mountain Educational Lab., Inc., Greeley, Colo. 1969. 70 p.

The Rocky Mountain Educational Laboratory (RMEL) Health Occupations Curriculum project was initially structured to provide broad exploratory activities for the total student body, an elective course, orientation to employment, and work entry experience in the 11th and 12 grades. It was expected that the project would provide a prototype for rural school systems which would be transferable to the urban setting and to other occupational clusters. This paper deals only with the activities and experiences associated with the 11th-grade health occupations curriculum development, in the hope that other educational agencies might be able to reduce their planning effort through utilization of the RMEL experience. The appendix includes a sample questionnaire consisting of performance elements to be checked in terms of importance and the setting appropriate for teaching of the element by 11th-grade teachers, the health-occupations teacher-coordinator, health services-administrators, supervisors, and job incumbents. (ERIC/JK)

293. ROWE, Harold R. *A Health Career Development Program for the Rural High School.* Ohio State Univ. The Center for Vocational and Technical Education, Columbus, Ohio. 1970. 120 p. Research Series No. 56.

Four of the major problems facing rural American communities in their development of health-occupations education programs are: too few trained health workers, the inability to attract health workers trained outside the area, the lack of opportunity for rural students to explore health-services careers, and not enough money. This is a report of an Office of Education project intended to provide data for designing a curriculum for a health-career program in the rural high school. It was aimed at the 11th and 12th grades. The curriculum objectives are to offer information about health-career opportunities, to provide opportunities to develop skills and knowledge useful to a cluster of health occupations, and to provide a foundation for more specialized health-care training in a post-secondary program. Ten entry-level health occupations were selected: ambulance attendant, dental assistant, dietary aide, medical assistant, medical laboratory assistant, medical records clerk, nurse aide, surgical technican, visiting home health aide, and ward clerk. (MAP)

1. CONTINUING EDUCATION FOR HEALTH MANPOWER
2. ADULT AND CONTINUING EDUCATION
3. PREPARATORY EDUCATION

3.2 Technical and Vocational Education

4. HEALTH-CARE SERVICES

294. LIGHT, Israel. "Development and Growth of New Allied Health Fields". *Journal of the American Medical Association.* Oct. 6, 1969. pp. 114-120.

The author says that before developing a new allied health specialty at any level a number of often overlooked implications and possible consequences should be noted. There should be a thorough job analysis of an entire specialty or functional area when developing health-assistants categories, the allocation or re-allocation of responsibilities, and then careful planning and construction of curriculum. He defines two different but related types of task analysis – "job factoring" and developmental analysis. The first stresses job development and the point of view of the professionals rendering service; the second stresses career development and the needs and requirements of patients. Light's other points are: (1) It is first necessary to distinguish between legitimate specialization and unwarranted fragmentation; (2) functions, duties, responsibilities, and skills needed for optimum patient care and service must then be identified and described as a basis for valid job descriptions; (3) the orderly, coordinated development of new specialties, or competency levels, or both, within established health occupations requires that medical specialists reexamine their own forms of job descriptions; (4) health teams will become more effective and efficient to the extent that team captains share responsibilities rather than delegate duties; (5) major elements of curriculum planning include many questions and problems (notably certification of experience, program design, job advancement opportunities, and core curricula) which demand the intimate cooperation of specialists and professional educators; (6) obligations to trainees include geographic and occupational mobility, competitive wages, and distinctly visible membership on the health care team; (7) some form of organized medical specialty leadership must become involved in development at the very earliest stages. Progress in allied health career development is already occurring in such fields as speech therapy, dietetics, orthopedic surgery, and nursing home operation. (LY)

295. KINSINGER, Robert E., Editor. *Health Technicians.* J.G. Ferguson Publishing Co., Chicago, Ill. 1970. 377 p.

This is a detailed examination of 25 major career areas in the health field, written by specialists in those areas, showing more than 150 kinds of jobs available to technical health program graduates. Each area is discussed in relation to the type of work done, personal qualifications, high school and post-high school requirements, entry-level jobs, advancement possibilities, licensure and certification, work environment, and salaries and benefits. Also included is a geographical listing of 1,890 educational institutions offering programs in these areas. (MAP)

296. TRAPP, David C. *Health Careers: A Report on Training Programs in the State of Washington.* Washington State Library, Olympia, Wash. 1971. 38 p.

This is a report of the Washington State Health Manpower Project, Division of Health, Department of Social and Health Services. Between 1968 and 1971 the project collected data from schools, colleges, universities, private vocational schools and hospitals on health-careers training programs. It includes career-descriptions, training programs, addresses of institutions, enrollment and graduation figures, and student financial aid. (MAP)

297. KINTGEN, Jean. *Interpretation of Literature on Career Ladders and Lattices in Health Occupations Education.* ERIC Clearinghouse on Vocational and Technical Information. Ohio State Univ. Center for Vocational and Technical Education, Columbus, Ohio. 1970. 29 p. Information Series No. 23.

This bibliography brings together the diverse kinds of documents that might assist persons developing programs and/or doing research related to ladder and lattice concepts (or vertical and horizontal mobility) in both the educational and employment aspects of the health field. It was compiled by a computer search through August 1969 and a supplementary manual search through June 1970 of *Research in Education* (RIE); a manual search of *Abstracts of Research and Related Materials in Vocational and Technical Education* (ARM) through Spring 1970; and a manual search of the Clearinghouse collection. There are 56 documents in the bibliography, with information on availability. (RJB)

298. KAHLER, Carol. *Investigation of the Feasibility of Establishing Health Technology Demonstration Centers. Final Report.* National Health Council, N.Y. 1970. 63 p.

This investigation studied the feasibility of establishing a network of centers to demonstrate model programs in the health technologies. It was necessary to: (1) identify colleges with multiple health-related programs; (2) identify campus health-related programs which have recognizable strengths; (3) further define "recognizable strengths" through site visits to a sample of these programs; (4) designate health technician occupational areas for which few or no satisfactory programs are now available; and (5) utilize the data gathered to reach conclusions about a feasible plan which would assist two-year colleges seeking to initiate or improve health technician programs. A compilation of the results from reporting colleges showed great variation in the number and types of health-related programs available within each of 10 national regions. However, the findings revealed that a good potential network of demonstration centers exist. For best results, a mechanism will be required that will tie present innovative elements into a dissemination system. This system should provide for the sharing of scarce research personnel, help health practitioner associations extend their services, and provide an instrument for disseminating information and sharing contributions to program development. (ERIC/DS)

299. CARNEGIE COMMISSION ON HIGHER EDUCATION. *The Open-Door Colleges: Policies for Community Colleges.* McGraw-Hill, N.Y. 1970. 74 p.

This, the third special report of the Carnegie Commission on Higher Education, discusses the role of community colleges (the fastest growing segment of higher education in the United States today) and proposes policies for their future development. Topics include: goals for the development of comprehensive colleges, the size of two-year institutions, future enrollments and new community colleges, financial support, governance and accreditation. "Occupational programs in community colleges are constantly increasing in size and scope. The larger and more complex the labor market, the more varied the occupational curricula of the community colleges are likely to be." (MAP)

300. AMERICAN HOSPITAL ASSOCIATION. *Hospital-Junior College Survey.* American Hospital Association. Bureau of Manpower and Education, Chicago, Ill. 1970. 9 p. plus 56 p. of tables.

This is the report of a survey made in 1969 to identify the extent to which hospitals are currently working with local junior colleges by providing the hospitals' clinical setting for the education and training of students for health-service occupations. A one-page questionnaire was sent to all registered general hospitals in the United States and Puerto Rico, except those under Federal control. About one in four are used for the clinical education of junior college students. (RJB)

301. ROSARII, Mary. "The Allied Health Student as a Hospital Employee". *Journal of the American Medical Association.* Sept. 7, 1970. pp. 2054-2057.

Hospitals have often tried to alleviate their growing personnel and financial problems by hiring student nurses and other allied-health students. Educators who oppose this practice maintain that students should be prepared as practitioners, not exploited. Other educators feel that students should be free to work for hire, at least on a limited, properly supervised basis. However, in combating exploitation, some health professionals have denied students the opportunity to relate with other professionals, live out the expectations of their commitment, or acquire a sense of independence in practicing their particular specialty. In any event, allied-health science internships should enable students to implement classroom and seminar learning so that they can gain skills while rendering genuinely useful services. Instead of emphasis on clock hours and courses per se, the author suggests the concept of program objectives and educational specifications based on job descriptions, human relations, concepts and problem-solving, technical skills, and data. Consideration should also be given to dual appointments for faculty, one on the college faculty and one in the primary affiliating hospital. There are eight references and PERT (Program Evaluation and Review Technique), of a two-year health science curriculum at Moraine Valley Community College, Illinois. (LY)

302. HOLLOWAY, Lewis D. and KERR, Elizabeth E. *Review and Synthesis of Research in Health Occupations Education.* Ohio State Univ. Center for Vocational and Technical Education, Columbus, Ohio. 1969. 97 p. Research Series No. 39.

Sources of the materials presented are: (1) Educational Resources Information Center (ERIC) publications, (2) Dissertation Abstracts, (3) Masters' Theses in Education, and (4) Nursing Research. In addition, approximately 200 letters were sent to governmental agencies, universities, schools, and professional organizations to locate studies relevant to the review. Materials, most of which were published after 1963, are organized into 13 major sections. Sections and subsections are as follows: (1) Philosophy and Objectives, (2) Manpower Needs and Employment, (3) Curriculum Development, (4) Educational Programs, (5) Instructional Materials and Devices, (6) Learning Processes and Teaching Methods, (7) Student Personnel Services, (8) Facilities and Equipment, (9) Teacher Education, (10) Administration and Supervision, (11) Evaluation, (12) Research, and (13) Other. Among recommendations are: (1) increased Federal and State funds for research, (2) in-depth analysis of functions to determine preparation for needed roles, (3) college and university programs to prepare teachers, researchers, and other leaders, (4) effective dissemination of research and other resources, and (5) increased cooperation among vocational education and health oriented agencies and organizations to solve educational problems. (ERIC/JK)

303. PHILLIPS, Donald S. and BRIGGS, Lloyd D. *Review and Synthesis of Research in Technical Education. Second Edition.* Ohio State Univ. Columbus. Center for Vocational and Technical Education, Columbus, Ohio. 1969. 50 p. Research Series No. 47.

This document provides an analysis and synthesis of some of the research in technical education since August 1966, and in some instances before. An overview of research is provided in the following areas: (1) philosophy, (2) manpower needs, (3) educational programs, (4) curriculum, (5) student personnel services, (6) evaluation, (7) administration and supervision, (8) teacher education, (9) learning processes and teaching methods, (10) instructional materials and devices, (11) facilities and (12) research. It was concluded that: (1) in general, much of the research suffers from deficiencies in design and methodology; (2) descriptive research studies have limited value; (3) limited information was available about development and validation of questionnaires and opinionaires when used; (4) research studies dealth with small segments of large problems and tended to be terminal; and (5) the amount of significant research in technical education is still small. An extensive bibliography is appended. (ERIC/GR)

304. LARSON, Milton E. *Review and Synthesis of Research: Analysis for Curriculum Development in Vocational Education.* Ohio State Univ. Center for Vocational and Technical Education, Columbus, Ohio. 1969. 82 p. Research Series No. 46.

This "State of the art" paper is intended to provide researchers, curriculum development specialists, and practitioners with an authoritative analysis of the literature in the field. Major sections include: (1) Background and Structure, (2) Resource Materials, (3) Sources of Content Information for Analysis, (4) Types and Techniques of Analysis, (5) Translating Content into Courses of Study, (6) Building Curriculum from Analysis, (7) Systems Approach to Building Vocational Curriculum, and (8) Trends and New Directions. It was concluded that more serious considerations must be given to: (1) increasing the use of analysis as the foundation for vocational curriculums, (2) codifying and defining terms used, (3) developing common understandings of effective processes of analysis, and (4) accepting procedures found to be functional by other vocational services. A suggested approach to providing validated vocational curriculums would be the establishment of a center(s) for the unique purpose of curriculum building. (ERIC/JK)

305. PARKER, J.C. and RUBIN, Louis J. *Process as Content: Curriculum Design and the Application of Knowledge.* Rand McNally and Co., N.Y. 1969. 75 p. Curriculum Series No. 1.

The editor and co-editor of the Rand McNally Curriculum Series examine varying patterns or models for creating and using process-centered curricula.

Although aimed primarily at public school and higher education, this book has point for continuing education and training. The authors consider it a mistake to make a sharp distinction between process and content. "Process -- the cluster of diverse procedures which surround the acquisition and utilization of knowledge – is, in fact, the highest form of content and the most appropriate basis for curriculum change. It is in the teaching of process that we can best portray learning as a perpetual endeavor, and not something which terminates with the end of school. Through process, we can employ knowledge, not merely as a composite of information, but as a *system* for learning." "The requirements posed by a process-based curriculum deal primarily with the identification of worthwhile processes to which the student should be exposed, the design of instructional strategies that make effective use of the processes, and the realignment of subject matter so that it complements the instructional strategies." Finally, the authors offer their own interdisciplinary process-centered planning model. It begins with *intake* or acquisition of ideas and data from many fields, goes through the *manipulative* phase (arrangement and classification of new learning), and ends with *application*, at which point a learner should be able to solve problems in many different areas. (LY)

306. HAMBURG, Joseph. "Core Curriculum in Allied Health Education". *Journal of American Medical Association.* Oct. 6, 1969. pp. 111-113.

Approaching the problem of curriculum planning for allied health specialities or occupations, Hamburg proposes an undergraduate core curriculum based on four broad groupings: environmental, communicative, interpretive, and directive. The first grouping (also called "man and his environment") would cover the natural and social sciences on a unified, problem-centered basis, and would probably be equivalent to two laboratory courses of two-years' duration, or a total of 20 credit hours. The other three groupings would be set up as follows: (1) health terminology, interview and communication techniques, computer science; (2) health ethics, behavioral science, statistics; (3) emergency care and preventive medicine. (ERIC/LY)

307. FULLERTON, Bill J. and others. *The Identification of Common Courses in Paramedical Education.* Arizona State Univ. College of Education, Tempe, Ariz. 1966. 172 p.

Integration of paramedical education through consolidation of related training was studied as a first step in curriculum development for maximum efficiency of education programs which will meet the changing requirements of medical care occupations. The objectives were to determine (1) courses common to present paramedical education programs, (2) the nature of such commonalities, (3) guidelines for the integration of such programs. All major medical, dental and paramedical groups from university, junior college, high school, and hospital programs in a metropolitan area were represented in a workshop of 24 paramedical educators who met weekly for six months. Members of the

workshop gathered curriculum materials for 20 paramedical careers from 126 education programs consisting of 2,613 course titles in 110 separate institutions throughout the United States. Computer print-outs listed careers, courses, subject classifications, and related descriptive data such as number of clock hours for each in lecture, lab, and clinical experience. Of the 126 general subject classifications, 78 were common to two or more paramedical fields. There appeared to be a difference of opinion among curriculum developers of paramedical education programs and a need for a study in each of the paramedical careers of the tasks performed by the practitioners. (ERIC)

308. WALLENSTEIN, Robert J. *Knowledge Commonly Useful in Twelve Allied Health Occupations.* Washington State Coordinating Council for Occupational Education, Olympia, Wash. 1968. 101 p.

This is the report of a study conducted to determine what commonalities of knowledges exist for 12 allied-health occupations (dental assistant, dental technician, occupational therapy assistant, physical therapy assistant, medical assistant, medical records technician, cardio-pulmonary technologist, registered nurse, X-ray technician, medical secretary, and medical laboratory technician). The author consulted with instructors, practitioners, and supervisors; he field-tested 279 knowledge items ("knowledge" as used in this study involves the "recall of specifics and universal, the recall of methods and processes, or the recall of a pattern, structure or setting") from the disciplines of anatomy, physiology, microbiology, physics, chemistry, psychology, and sociology. Wallenstein concludes that "the greatest degree of common usefulness is among knowledges most directly associated with patient care," and that "the humanistic nature of the work performed by all allied health workers directly involved with patient contact and functioning in the health-team role involves some use of knowledge from sociology and psychology." (MAP)

309. TOMLINSON, Robert M., LANGDON, Lois M. and RZONCA, Chester S. *Guidelines for Health Occupations Education Programs.* Univ. of Illinois. College of Education. Department of Vocational and Technical Education, Urbana, Ill. 1971. 41 p.

The Office of Education, Bureau of Adult, Vocational and Technical Education, in 1969 awarded a series of contracts to conduct a national conference on and develop a set of guidelines for activities in specific areas of health-occupations education. The *Guidelines*, with recommendations and suggested procedures should assist local, regional and state personnel as they design programs and promote correlated action to meet the educational needs of health occupations. Four appendices give supplemental references and resource information. (MAP)

310. FLORIDA STATE DEPT. OF EDUCATION. *Guidelines for the Training of Central Service Aides.* Florida State Dept. of Education. Division of Vocational, Technical and Adult Education, Tallahassee, Fla. 1969. 24 p. Bulletin 77L-6.

Guidelines are spelled out for basic preservice education of supportive health workers (Central Service Aides) to perform tasks which involve caring for, preparing, sterilizing, dispensing, and storing materials and equipment and materials within hospitals and/or nursing homes. Such points as student and instructor qualifications, student certificates, allowable credit for experience, teaching methods and materials, and class size are covered, together with time allotments, objectives, and content for a preservice short course. Also included are a sample course outline, 18 references, suggested equipment and supplies, and suggestions on contractual agreements. (ERIC/LY)

311. OHIO STATE UNIV. CENTER FOR VOCATIONAL AND TECHNICAL EDUCATION. *Writing Performance Goals: Strategy and Prototypes: A Manual for Vocational and Technical Educators.* Gregg Division/McGraw-Hill Book Co., N.Y. n.d. 101 p.

This volume explains methods and procedures with examples to aid teachers, administrators, and supervisors in defining the capabilities to be acquired by students. Part I deals with preparing performance goals. Among the prototypes of performance goals in Part II is a discussion of health education: "The technological changes, the changing role of the professional health person, the changing concepts in the health assistant's education, and the increasing use of the assistant are indicative of the need to emphasize performance goals in the health occupations." The prototypes given in this section are: loading and operating mechanical sterilizers, scheduling and assisting dentist in performing treatments, interviewing a patient and admitting him to hospital, cleaning and making hospital beds, and transcribing and transferring doctor's orders in assisting the nurse. (MAP)

312. NORTHWEST REGIONAL EDUCATIONAL LABORATORY. *Vocational Instructional Materials for Health Occupations Education Available from Federal Agencies.* Northwest Regional Educational Laboratory, Portland, Ore., 1971. 50 p.

This annotated listing is the result of a 1970-71 survey of curriculum materials produced by Federal agencies and directed toward teachers preparing students for occupational objectives in diagnostic, therapeutic, preventive, restorative and rehabilitative services to patients. The areas are: dentistry, medical laboratory technology, nursing, rehabilitation, radiology, opthalmology, environmental health, and mental health technology. Information on ordering selected documents is included. (MAP)

313. TRAINING IN BUSINESS AND INDUSTRY "How Army Doctors Use TV to Teach Recruits to Be Medics" *Training in Business and Industry*. July 1971. pp. 38-48.

The Army needed a method to train 30,000 medics a year in a ten week course. Their most successful method is a combination of audiovisual techniques, live instruction, and experience training. (ERIC/AS)

314. WARMBROD, Catherine P. *Review and Synthesis of Literature on Residential Schools in Vocational and Technical Education.* Ohio State Univ. Center for Vocational and Technical Education, Columbus, Ohio. 1970. 41 p. Information Series No. 31.

Residential vocational school programs have been authorized in federal legislation, and a few have been established in spite of the lack of appropriate funds. The three acts in Federal legislation of primary importance to residential schools are the Vocational Education Act of 1963, and 1968 Amendments and the Economic Opportunity Act of 1964. The Job Corps, as created by the 1964 Act, involved operating residential schools. and offers data on many aspects of the problem. Other examples of residential schools reviewed are the Hashell Institute in Kansas, Mahoning Valley Vocational School in Ohio, and Mayo State Vocational School in Kentucky. Residential schools provide a healthy learning and social environment for the urban disadvantaged, and an opportunity for youth in remote rural areas to receive vocational training. The residential vocational school can fill a gap in our present educational system and can play a much larger role than is currently being considered. State governments, therefore, should incorporate residential schools in their plans for vocational education. (ERIC/Author/JS)

315. ALKIN, Marvin C. *Evaluating the Cost-Effectiveness of Instructional Programs.* California Univ. Center for the Study of Evaluation of Instructional Programs, Los Angeles, Cal. 1969. 36 p. From the Proceedings of the Symposium on Problems in the Evaluation of Instruction (Los Angeles, December, 1967).

A model of cost-effectiveness is outlined which enables consideration of some non-financial, as well as financial, elements of educational systems at school or district levels. The model enables the decision-maker to compare educational outcomes of different units, to assess the impact of alternative levels of financial input, and to select alternative approaches to reach specified educational outcomes. Components of this model are student inputs, educational outputs, financial inputs, external systems, and manipulatable characteristics. Indicated are the potential applications of the model in different evaluation situations and its use to evaluate the cost-effectiveness of various financial inputs and of individual school programs. (ERIC/Author/MF)

1. CONTINUING EDUCATION FOR HEALTH MANPOWER
2. ADULT AND CONTINUING EDUCATION
3. PREPARATORY EDUCATION

3.3 Professional Education

4. HEALTH-CARE SERVICES

316. MAYHEW, Lewis B. *Changing Practice in Education for the Professions.* Southern Regional Education Board, Atlanta, Ga. 1971. 90 p. SREB Research Monograph No. 17.

Surveying the major professional fields, the author finds them all in varying degrees of discontent, reappraisal and reform. They are all tackling the same problems: theory versus skills, specialization versus broad bases, whether to prepare candidates for their first jobs or to give them a broad foundation for continued development, the thrust toward subprofessions and the relations between the parent profession and among the offspring, content versus process, whether the professional schools should seek to bring about innovations in the professions, how to select the faculty, the relations between the professional school and the university, innovative teaching methods (such as earlier and more field experience), the use of the new media, how much to stress international aspects of the profession, and how much attention to pay to values and ethics and professional identity and how to achieve the desired attitudes. "The last element of curricular reform – continuing education – has developed from an impressive set of premises but has turned out to be a puny effort on the part of the professional field." Cooperation between the profession (whatever it may be) and the social and behavioral sciences seems so necessary and of such mutual benefit that, despite difficulties such as the nature of the cooperative relationships, differing technical language and the applicability of research findings from one field to another, ways of cooperation must be found. More interdisciplinary contacts, field experience and competent supervisors are needed. Program content must have personal, social, educational and economic relevance. Behavioral objectives of education must be specified and outcomes evaluated. More attention must be paid to retraining and continuing education. (RJB)

317. SCHEIN, Edgar H. *Professional Education: Some New Directions.* McGraw-Hill Book Co., N.Y. 1972. 163 p.

In this report for the Carnegie Commission on Higher Education, the author, chairman of the Organization Studies Group of Massachusetts Institute of Technology, argues for four general directions of changes in professional schools: (1) more flexibility in the professional school curriculum, (2) more

flexibility in the early career paths of professionals, (3) new curricula and new career paths that are inter- or transdisciplinary, and (4) greater integration of the behavioral and social sciencies into the professional school curriculum at three different levels: First, basic psychology, sociology, anthropology, etc., as a part of the core of professional education; second, applied behavioral science dealing with the theory and practice of planned change, diagnosis of complex systems, and analysis of client-professional relationships; and third, applied behavioral science dealing with self-insight, social responsibility, learning how to work in and lead professional teams, and learning how to learn. The book does not deal with continuing education except inferentially. The inference is explicit in the final chapter's proposal for a "new kind of faculty" – one that is learning-centered rather than teaching-centered, and that knows the psychology and sociology of learning. The inference is implicit in discussions of "planned change" and "self-insight." The longest chapter, 10 – "Innovative Mechanisms for Professional Education" – gives numerous examples (self-paced study, independent study, concentrated study, small-group and seminar-tutorial methods, project- or problem-centered study, workshops and other concentrated postgraduate educational activities), that have relevance to continuing education and training. (RJB)

318. EVANS, Lester J. *The Crisis in Medical Education.* The Univ. of Michigan Press, Ann Arbor, Mich. 1965.

The crisis in medical education, which is the crisis in education for all health professions, is whether it will prepare the professional for his primary task of human service or merely as a competent technician. Beginning a hundred years ago medicine reached outside itself for help from the natural sciences. Following the Flexner recommendations, medical education in the United States shifted from the proprietary schools to the universities. Its success from being rooted in the physical and biological sciences has been and continues to be so great that "university and medical education have tended to become more disease-oriented and less patient-oriented" at the very time that the society is demanding better health care for the whole person and better health-care delivery for all people. Now medicine needs to reach outside itself again, this time for help also from the basic arts, humanities and behavioral and social sciences. Will it do so and will the university be flexible enough to respond? The alternative is that medical education will lapse into a midtwentieth century form of proprietary professional education, the symptoms of which are already in evidence. The basic questions in medical and health professional education today revolve around two problems: "(1) to discover the student in the scientific and clinical organizational structure of the medical school and its appurtenances as the reason for medical and health profession education, and (2) to rediscover the patient in his equally complex diagnostic and treatment setting as the reason for medicine and without whom the student cannot learn." The author believes that only true university education drawing on the sciences, biological, physical, and behavioral, as well as the arts and humanities, can prepare the health professional for his broad responsibility. His treatments of professional education as a truly liberal education, of the "health team" and of the need for professional administrators of public health and health-care delivery programs are notably good.

The author was an official of the Commonwealth Fund, associated with New York University in rehabilitation and director of the New York State Committee on Medical Education. (RJB)

319. MILLER, George E., Editor. *Teaching and Learning in Medical School.* Harvard Univ Press, Cambridge, Mass. 1961. 296 p.

This was probably the first reference book on teaching and learning designed for medical educators. Its aim is to induce re-examination of many education techniques that have become entrenched in medical schools. The authors attack some traditional methods, suggest improvements for others, and point out new practices. The book is divided into four parts: the medical student, the process of learning, the tools of instruction, and the evaluation of learning. It is an important early source book of ways in which contemporary principles of education, psychology and methodology can serve the medical faculty. (MAP)

320. McCREARY, John F. "The Health Team Approach to Medical Education". *Journal of the American Medical Association.* Nov. 11, 1968. Vol. 206, No. 7, pp. 1554-1557.

This is an early report by a member of the faculty of Medicine, University of British Columbia, on the background and planning years of the University of British Columbia's Health Science Centre. The concern began with the recognized failure to meet the challenge of primary health care. "It seemed . . . that one of the major requirements for the future was to expand the influence of the diminishing number of primary care physicians. . . . We decided to attempt . . . to integrate the teaching of the existing health professions in such a way that they might better understand and appreciate what each professional group could contribute. If by so doing we could create a more meaningful role for the allied health professions and thereby attract more people to them, the need for a new and special type of assistant would be obviated. If this phenomenon fails to materialize, a new type of medical assistant could still be trained in the same facilities." McCreary concludes: "Perhaps the greatest single problem associated with the development of interprofessional education in the health sciences is the lack of a model. . . . The model must be produced from whole cloth; . . . after five years of active concentration in this area, the faint glimmerings of such a model are beginning to appear." (RJB)

321. HICKS, Dora A. "Professional Preparation of Health Educators in the 70's". *The Journal of School Health.* April, 1972. pp. 243-245.

This paper, presented before the Committee on Professional Preparation in Health Education at the Meeting of the American School Health Association, October 8, 1971, describes the personal, educational and professional characteristics required of the health educator in the seventies, and outlines the reforms (of faculties, curricula, and institutions) necessary effectively to prepare this health educator. (MAP)

322. COMBS, Arthur W. and others. *Helping Relationships: Basic Concepts for the Helping Professions.* Allyn and Bacon, Inc., Boston, Mass. 1971. 336 p.

Written for people who are entering or who are already engaged in some form of the helping professions, this book attempts to answer the following questions: "What ideas about human behavior have special value for understanding the helping relationship?" "What do these imply for effective practice in the helping professions?" Concepts discussed are: What Is a Professional Helper? Two Ways of Looking at Behavior; Self-Concept: Product and Producer of Experience; A Humanistic View of Motive; The Crucial Character of Meaning; Learning as Meaning Change; The Limits of Man's Becoming; Freedom and Self-Actualization; Goals and Purposes of Helping; Developing Understanding; Establishing Helping Relationships; Aiding the Search for New Meaning; Communication; Varied Roles of Helpers; and The Helper as Person and Citizen. Selected Readings, related to the topics in the chapter, are listed at the end of each. (ERIC/DB)

323. NATIONAL INSTITUTES OF HEALTH. Bureau of Health Manpower Education. (DHEW) *Computer Applications in Dental Education: A Conference Report.* G.P.O., Washington, D.C. 1969. 199 p.

This is the report of a conference held in San Francisco October 29-31, 1969 and sponsored by the Professional Education Branch of the Division of Dental Health, Bureau of Health Manpower Education, National Institutes of Health. It was attended by representatives of 35 American and Canadian dental schools, staff members of the Division of Dental Health, and by observers from the National Library of Medicine and the Division of Physician Manpower, BHME, NIH. The purpose was to stimulate cooperation among the schools already using computers for instruction, and to provide some documentation for other schools considering the use of computers. Part I consists of seven formal presentations by invited speakers; Part II summarizes computer projects in progress at the dental schools represented. (MAP).

324. HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION. Community Health Service. (DHEW) *1971-72 Graduate Education in Comprehensive Health Planning.* G.P.O., Washington, D.C. 1971. 22 p.

This document points out that the comprehensive health planning process requires persons with a variety of skills, including a firm understanding of the health industry and community dynamics, and analytic and planning techniques. To train such personnel, the Division of Comprehensive Health Planning is supporting graduate education programs at 22 institutions of higher learning. This report describes the didactic and field work requirements at each of these institutions, with information about applications, degrees offered, and course length. (MAP)

325. BENSON, A.E. and CARY, Lee J. *Community Development: A Director of Academic Curriculums Throughout the World.* Missouri Univ. School of Social and Community Service, Columbia, Mo. 1969. 76 p.

Descriptions of academic curriculums and courses, admissions requirements, staffing, and degree or certificate awarded, for thirty graduate and undergraduate programs in community development are included in this directory. The programs are divided into five groups: those offering graduate degree in community development; those offering diplomas or certificates in community development; those offering graduate degrees in a related field with a major or emphasis in community development. More than half of the programs cited are in the United States; the remainder are in the British Isles, Canada, the Philippines, Denmark, Uganda, and Hong Kong. Programs vary in emphasis; both urban planning and rural development are included. (ERIC/MF)

326. WALKER, E.A. and others. *Final Report of the Goals Committee.* American Society for Engineering Education, Washington, D.C. 1968. 446 p.

In November 1961, the American Society for Engineering Education established a study project, "Goals of Engineering Education." Chaired by Eric A. Walker, the committee was to determine the basic educational needs and goals of engineers for the next decade, delineating the scope of education necessary to fill these needs, evaluating the current engineering education, and examining the facets of post-baccalureate education, degrees and accreditation. This is a report of investigations carried out from 1963-1968, with data from engineering educators, practicing engineers and employers of engineering talent. The book is organized: The Engineer in Future Society, Basic Engineering Education, and Advanced Engineering Education. The committee concludes that the engineer's education of the future must have greater breadth as well as depth, and it therefore recommends an increased recognition of the place of continuing education as a continuing objective in engineering education. (MAP)

327. OHIO STATE UNIVERSITY. *Recurring Bibliography Education in the Allied Health Professions,* Vol. 4. School of Allied Medical Professions, The Ohio MEDLARS Center, Columbus, Ohio. March 1972. 20 p.

1. CONTINUING EDUCATION FOR HEALTH MANPOWER
2. ADULT AND CONTINUING EDUCATION
3. PREPARATORY EDUCATION
4. HEALTH-CARE SERVICES

4.1 Health Care, General

328. JONES, Boisfeuillet, Editor. *The Health of Americans.* Prentice-Hall, Inc., Englewood Cliffs, N.J. 1970. 192 p.

These seven essays, background papers for the 1970 American Assembly, make probably the best primer on the nation's health-care needs and problems. Julius Richmond contrasts the advantages of a concern for enhancing human development potential over a concern merely for treating disease; the months before and immediately after birth and the early years of childhood are fertile periods for vigorous preventive measures. William Stewart makes clear that further dramatic decreases in death- and sickness-rates are unlikely without some fundamental breakthrough in prevention and treatment of the major diseases of old age; he says we need new and better ways of measuring health than crude figures of death and disease. Harold Rome, who puts mental illness in historical, social and cultural context, thinks that improvement in the American people's mental health will require an adjustment of the individual's patterns of reaction to the current social, cultural environment. William Hubbard finds present biomedical research strategies insufficient to cope with such complex problems as accidents, obesity, drug abuse, poverty, overpopulation and destructive behavior; he suggests an "ecological" approach and educational strategies that stress self-care and the use of health manpower to emphasize prevention and maintenance. James Goddard spells out the staggering dangers to our environment and the urgent needs for research and planning to avert the dangers and to restore a healthful physical environment; technical solutions must be accompanied by appropriate political and economic measures, he says. James Appel analyzes the major deficiencies of our present system of health-care delivery and calls for a setting of priorities, for the provision of the full range of health services in each community, and for more attention to the health of the patient and less to the treatment of the disease. Herman Somers analyzes health-care costs; any attack must take all factors into account and, even so, can expect not to cut costs but only to contain them. (RJB)

329. WILSON, Robert N. *The Sociology of Health: An Introduction.* Random House, N.Y. 1970. 134 p.

This book has special merit for inservice education programs and continuing education courses. The author offers a variety of definitions of illness and health, making the point that neither can be described in a definitive manner which will appropriately serve for all people, places, and times. The

relationships between traditional health workers and patients are reviewed as well as the role behavior of professional workers and the person in sickness and health. From the sociology of people concepts, the author moves into such broader areas as the complex character and organization of health-care institutions and the comprehensive framework of the community. By examining such factors as geography, age, sex, race, socioeconomic status, life styles, and the public reaction to illness and health, a knowledge of why people will or will not participate in health programs and what influences their chances of staying well or becoming sick is gained. (AJN)

330. SAUNDERS, Lyle. *Cultural Difference and Medical Care: The Case of the Spanish-Speaking People of the Southwest.* Russell Sage Foundation, N.Y. 1954. 245 p.

This still valuable book has two main purposes: to give information about the Spanish-speaking people of the American Southwest that may be helpful to medical and related professional people who work with members of that subculture, and to use the situation of these people and their relationships with the English-speaking population in order to generalize about medicine and culture and the interrelationships between them. Saunders contends that better health care results if doctors know something about culture differences and how these factors affect the doctor-patient relationship, and if they modify their practice accordingly. (MAP)

331. BERKI, Sylvester E. and HESTON, Alan W., Editors. "The Nation's Health: Some Issues". *The Annals of the American Academy of Political and Social Science.* Jan. 1972. 174 p.

The editors of this special volume write that the multiplicity of proposals for the cure of gaps in terms of delivery, organization and financing and control of the health care system is evidence that public dissatisfaction has reach the status of a politicized social problem. This volume has four maj divisions: "Medicine: The Poor, The Sick, The Student"; "Hospital and Physician Costs and Charges"; "The Experience with Medical Provision and Insurance Programs in the U.S."; and, "Problems of Health in the U.S. in Perspective." (MAP)

332. GINZBERG, Eli and OSTOW, Miriam. *Men, Money, and Medicine.* Columbia Univ., N.Y. 1969. 292 p.

The study, a collection of essays dealing with critical health occupations and their workers, delineates the ways in which American medicine is rooted in the larger fabric of the national life, and indicates changes that are involved if the health industry is to be significantly restructured. In part one, two themes are covered: What are reasonable expectations of a system of medical care for an affluent country in the presence of unmet needs? Next, what have been some of the important financial and manpower transformation of the system as the nation has attempted to improve both the provision and distribution of health services? In part two, the focus is on the critical role of the physician, who stands at the apex of the system and whose cooperation is required to accomplish significant changes. Part three is concerned with the ever-larger role played by allied health manpower. Particular note is taken of the potentialities and limitations of the leadership of specific occupational groups

in rationalizing their training systems and altering employment practices. Part four is concerned with illuminating the problems of persons suffering from chronic conditions and the extent to which their medical needs are affected by the socio-economic structure in which they live and work. (NTIS)

333. LATHEM, Willoughby. "Technology and Health". *Social Policy*. Jan./Feb. 1971. pp. 57-59.

The author, Deputy Director of the Bio-Medical Sciences Division, Rockefeller Foundation, argues that our health services, organized around the hospital, have not kept pace with technological advances in medicine or with society's changing attitudes toward medical care. He says that the health-care crisis is not caused by shortage of money but by poor organization, of the system: The fee-for-service has no place in providing health care; clinical medicine and public health should never have been made separate systems; the hospital should be made responsible for a specific constituency. Lathem contends that little reform can be expected from the medical profession; change must come from without- from the bill payers, the consumers. (MAP)

334. WHITE, Robert Lanon. *Right to Health: The Evolution of an Idea.* Univ. of Iowa. Iowa City, Iowa. 1971. 94 p. Health Care Research Series No. 18.

This "speculative essay" regards the demand for the right to health care as a stimulus to the health-care delivery system. It uses a system "survival model"—a system tries to ignore a stimulus, to accommodate to it or to suppress it; the task of the "agents of change" is to structure a stimulus that can and should be neither ignored nor suppressed so that it will be accommodated. White regards the demand for health care as a stimulus to be accommodated. "However, mere assertions that health care is a civic right do not make it one. Such assertions frequently fail to identify the point of guarantee or to specify the services encompassed within the right. There is considerable difference between expressions of human need and desire, postulations designed for their political impact, and demonstrable evidence of an operable civic right." ". . .if the State is to guarantee a right to health care, it might be expected that control of at least some of the particulars will shift either to the consumer or to the State. And the provider stands to lose his existing rights to freedom of action to the extent that control over these particulars is passed to others. . . .further, a right to health care may well impinge on consumer freedom, and not just in matters of choice of physician. . . .at a minimum, it would seem that the individual should be charged with a large measure of responsibility for his own health. . .If such duties could be made a formal counterpoise to a right to health care, at least some of the controversy over such a right would subside." In six chapters the book examines the origin of the notion of rights to health and health care, the current state of such rights in the United States, and the implications for the future of this evolving concept. (RJB)

335. MEDICAL AND HEALTH RESEARCH ASSOCIATION OF NEW YORK CITY. *Poverty and Health in the United States. A Bibliography with Abstracts.* Medical and Health Research Association of New York City, N.Y. 1967. 300 p.

The bibliography consists of literature on poverty and health in the United States covering the years 1960 through 1966. Studies which appraise the

health status of the poor, analyze the availability and quality of health services, investigate possible causes and effects of medical deprivation and proposals and programs for improving the health care of the disadvantaged were documented and abstracted. Although most of the citations are from American publications, selected articles from English language journals of foreign countries were included where the papers had some bearing upon aspects of health and poverty in the United States. (ERIC/Author/EB)

336. NATIONAL ASSOCIATION OF SOCIAL WORKERS. Task Force of Cleveland Area Chapter. *The Delivery of Health Services to the Poor in Cleveland.* National Association of Social Workers, Cleveland Area Chapter, Cleveland, Ohio. n.d. 39 p.

This study, begun in February 1968 and completed in June 1969, started from the premise that health care is a concern of all social workers, regardless of setting or method of practice. Over 200 Chapter members completed a questionnaire organized around four major subtopics: health-care needs and resources in low-income areas of Cleveland; the organization and delivery of health services, including current policies and practices in health-care insitutions; the role of the consumer in the delivery process; and the role and responsibilities of social workers in this process. Among the recommendations are: (1) the Cleveland Chapter should place major emphasis on manpower development in the health field, especially social work manpower; (2) social workers in health agencies should examine the extent to which they are fulfilling the responsibility for helping patients to understand health problems and practices and agency procedures; (3) the position of hospital "ombudsman" should be created as one means for health facilities to be more responsive and to identify obstacles to service; and (4) the medical profession should make use of social workers in the continuing education of physicians regarding the poor–their needs, reality problems, life-style, and orientations to health care. (MAP)

337. SNYDER, L.J. "Health Care in Rural America". *Outlook.* April 1971. pp. 12-16.

The chairman of the American Medical Association's Council on Rural Health writes that he has seen no "legitimate evidence of a real commitment to planning for solutions to the dilemma of distribution, delivery, and quality of health services in this country." He contends that the individual rural physician–overworked, without adequate lab and X-ray equipment, without a dependable referral system or enough time for vacation or continuing education activities–must be replaced by a health-care system developed by multiple communities on a regional basis and manned by personnel working in a group to provide home, clinic and hospital care. Snyder cites several solutions and promising experimental models, offers a list of elements for an ideal "Rural Health System," and refers to the AMA's "Guidelines for Community Organization for Rural Health Services." (MAP)

338. AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS. *Emergency Medical Services: Recommendations for an Approach to an Urgent National Problem.* American Academy of Orthopaedic Surgeons, Chicago, Ill. 1969. 82 p.

Medical technicians such as ambulance attendants must be trained to administer life-saving measures to the acutely ill and injured and transport them safely to a medical facility. Thus, the purpose of this conference was to bring together, for a discussion of all aspects of emergency medical services, representatives of all those groups which are currently involved in efforts to improve these services. The conference also sought to formulate some basic definitions of emergency care, and to establish workable guidelines for rendering emergency services. The materials collected in these proceedings have been agreed upon by the participants and represent a multi-disciplinary initial effort to meet the requirements of today, and to plan for the future. The 11 papers presented at the conference included: (1) "An Overview of the Planning, Organization and Management of Ambulance Services" by Joseph Owen, (2) "The Efficient City Emergency Medical System-Myths and Reality" by John Waters, (3) "Training Emergency Medical Technicians" by J.D. Farrington, (4) "Training Aids" by Walter Hoyt, and (5) "Registration, Certification, and Re-Certification of Ambulance Attendants" by Peter Safar. (ERIC/Author/JS)

339. HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION. Community Health Service (DHEW). *Community Health Service: Publications Catalog, 1971-72 Edition.* G.P.O., Washington, D.C. 1971. 50 p.

This annotated catalog lists then currently available publications related to activities and programs of the Community Health Service, and of other government and nongovernment organizations. Entries fall into ten categories: Adult Health and Aging, Bibliographies and Directories, Group Practice, Health Planning and Services, Home Health, Medical Care Administration, Medicare, Migrant Health, Nursing Homes, and Rural Health. (MAP)

340. EDWARDS, Sam A. and HURST, O. Ray. *Health Care System Variables: An Annotated Bibliography.* (Supplement) Health Resources Planning Unit, Texas Hospital Association, Trinity University, San Antonio, Texas. 1970. 234 p.

341. WILLIAMSON, John W. and TENNEY, James B. *Health Services Research Bibliography.* National Center for Health Services Research and Development, DHEW Publication No. (HSM) 72-3034. G.P.O., Washington, D.C. 1972. 58 p.

This bibliography was first compiled in 1968 for distribution to participants in a series of annual Health Services Research Seminars. It has been reviewed annually and updated by the same editorial committee, mostly members of the faculty of Johns Hopkins University. It is organized in 12 sections: (1) Health Services Research and Medical Care, (2) Health Services Manpower, (3) Health Services Facilities, (4) Health Services Provision and Utilization, (5) Medical Sociology, (6) Medical Economics, (7) Health Services and Continuing Education, (8) Health Services Policy and Planning, (9) Quality and Evaluation Research, (10) Health Services Research Methods, (11) Health Services Research Bibliographies, and (12) Additional Reference Literature. (RJB)

1. CONTINUING EDUCATION FOR HEALTH MANPOWER
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4.2 Assessment of Quality of Health Care

342. DE GEYNDT, Willy. "Five Approaches for Assessing the Quality of Care". *Hospital Administration.* Winter 1970. pp. 21-42.

This is probably the best short introduction to the subject because it makes explicit definitions and assumptions that are often obscured. De Geyndt distinguishes three kinds of care—"patient," "medical," and "health." Patient care is of the individual and focuses on disease. Medical care and health care include patient care but are successively broader. They emphasize the "appropriateness, availability, accessibility, and acceptability of a full range of services to prevent illness and disease and to maintain and restore health. Consequently, they encompass the social, economic, political and organizational aspects of the delivery of care not only to individuals but also to families as well as other groups. The focus in medical care is on the arrest of a pathological process and includes early diagnosis and physical rehabilitation. . .Emphasis bears heavily on disease and the medical aspects of the care process. Health care, on the other hand, goes further and encompasses preventive supervision, patient care, medical care and social rehabilitation or the maintenance or restoration of the individual. . . Health care is concerned with the quality of life in general, and with the production of a healthy populace." De Geyndt distinguishes and describes five approaches to assessing the quality of care: the assessment of (1) content, (2) process, (3) structure, (4) outcome, and (5) impact. He states the assumptions behind each approach and points out its pitfalls, with references to 36 studies, which are cited in a bibliography. Other bibliographies and noteworthy articles are listed below. (RJB)

343. DE GEYNDT, Willy and ROSS, Karen B. *Evaluation of Health Programs—An Annotated Bibliography.* Systems Development Project, Minneapolis, Minn. 1968. 107 p. Comment Series No. 8-9.

This annotated bibliography includes a review of more than 200 publications on the evaluation and assessment of health care services. The contents are segregated into the following seven categories: Bibliographies and Listings of Ongoing Research, Orientational Articles, Methodological Aspects, Applications in Current and Proposed Programs, the Role of Economics, Evaluation of Quality of Care, and Organization Theory and Research. After surveying the literature, the authors conclude "that, first, evaluative research is still in its infancy, and, second, most publications on evaluation of health programs extoll the virtues of evaluative research but offer little operational guidance." (RJB)

344. ALTMAN, Isidore, ANDERSON, Alice J. and BARKER, Kathleen. *Methodology in Evaluating the Quality of Medical Care: An Annotated Selected Bibliography, 1955-1968.* Univ. of Pittsburgh, Pittsburgh, Pa. 1968. 214 p.

This was prepared in the Department of Biostatistics of the Graduate School of Public Health, University of Pittsburgh, bringing the 1962 first edition, which covered the literature for 1955-61, through 1968. "Methodology" is loosely interpreted but accepted as being of two kinds–the methods employed in attempts to gauge quality, and analysis and critique of the methods themselves. The first kind outnumber the second. The 397 items are organized into four sections: standards and recommendations, elements of performance, effects of care, and general approaches. (RJB)

345. HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION. Regional Medical Programs Service (DHEW). *Selected List of References on Quality of Medical Care Assessment.* G.P.O., Washington, D.C. July 1972. 19 p.

Compiled by the staff of the RMPS Division of Professional and Technical Development, this is an alphabetized list of 255 articles, monographs and technical reports, most of which are later than 1965. (RJB)

346. HOPKINS, Carl E., Editor. *Outcomes Conference I-II: Methodology of Identifying, Measuring and Evaluating Outcomes of Health Service Programs, Systems and Subsystems.* Health Services and Mental Health Administration. National Center for Health Services Research and Development, Rockville, Md. 1970. 270 p. Held at Pacific Grove, Cal. on May 24-27, 1969 and Universal City, Cal. on Dec. 1-3, 1969.

The document contains discussions that took place at two conferences; each was designed to review the present state-of-the-art of measurement and evaluation of the effects, or outcomes, of health care services. The first conference is summarized in seven pages, and the bulk of the volume presents papers given at five sessions of the second conference. A wide range of outcomes are described and evaluated. These include conceptual models versus the real world of health service delivery; health improvement; indices of health; impact of health care services on the economy; and the neighborhood health center. (NTIS/Author)

347. WILLIAMSON, John W. "Evaluating Quality of Patient Care–A Strategy Relating Outcome and Process Assessment". *Journal of the American Medical Association.* Oct. 25, 1971. pp. 564-569.

This article builds upon research reported in two previous articles, and of all the literature the three have probably the most obvious implications for continuing education. The author asks, "*Who* needs to learn *what* to most improve health status of the population receiving care?" Previous studies have demonstrated (1) that there is an important relationship between patient-care assessment and education that might provide a framework for answering this question, and (2) that systematic application of this approach requires a priority list of health problems to be studied.

The first study dealt with physician response to apparently unexpected abnormalities in three routine screening tests in which it was found that physicians made no apparent response of any kind to approximately two thirds of the test abnormalities. In solving this problem, it was learned that systematic investigation is needed to identify education objectives that specify the individual who needs to learn, as well as the goals to be achieved in the learning process. The doctor, nurse, administrator, patient, or general public

might each contribute important elements of change to achieve needed improvement. After 'instruction,' the same methods of inquiry used to identify the problem can be reapplied to evaluate the impact of the educational effort exerted to solve the problem." (The study cited is Williamson, J.W., Alexander, M., Miller, G.E. "Continuing Education and Patient-Care Research: Physician Response to Screening Test Results." *JAMA* Vol. 201, Sept. 18, 1967

"The second study was concerned with methods for developing a list encompassing conditions involving the most preventable (or remediable) impairment. Given such a health problem of high priority, a strategy is then required to identify preventable impairment not being prevented (or remedied) by care presently provided." (The study cited is Williamson, J. W., Alexander, M., and Miller, G. "Priorities in Patient-Care Research". *JAMA* Vol. 204 April 22, 1968.)

The present article takes the next step, describing a strategy for evaluating the quality of patient care. A hospital staff sets criteria for acceptable performance outcomes of both diagnosis and therapy. The outcomes are routinely assessed. Where they meet the set criteria, no action is taken. But where they do not, the processes of diagnosis and/or therapy are examined. Thus the question is answered, *who* needs to learn *what* to improve patient care? Williamson illustrates the strategy in detail and concludes: "Since this strategy focuses continuing education resources on solving real problems in medical practice, it would seem to enhance educational effectiveness in two specific ways. First, it identifies learning needs, not only for the physician but for other health-care personnel and patients depending upon the problem. Second, it lends itself to educational assessment in terms of the objectives of the total care process, the improved health of those receiving care. Finally, if we focus on the ultimate purpose of the evaluation of a health-service system, namely, to facilitate improvement, the results of our experience would lead us to infer that the strategy described is definitely feasible and probably practical for this purpose. It offers an approach that may prove superior to the present haphazard method of planning patient-care studies and continuing education programs." (RJB)

348. MILLER, Winston R. *Quality Assurance of Medical Care.* Northlands Regional Medical Program, St. Paul, Minn. 1973.

The program director, Northlands RMP, wrote this pamphlet summarizing the proceedings of 28 papers presented to the Regional Medical Programs Service Invitational Conference on Quality Assurance of Medical Care, held in St. Louis, Mo., on January 22-24, 1973. (RJB)

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4.3 Dealing with Change

349. RIVLIN, Alice M. *Systematic Thinking for Social Action.* Brookings Institution, Washington, D.C. 1971. 158 p.

The author helped develop Planning-Programming-Budgeting System (PPBS) in the Department of Health, Education and Welfare and served there as assistant secretary for planning and evaluation during the Johnson Administration. She was also co-chairman, with Daniel Bell, of a HEW advisory panel that recommended the development of a set of "social indicators" to improve planning. Now with the Brookings Institution, she has assessed how much progress had been made by applying systematic methods to public policy. She concludes: "So far the analysts have probably done more to reveal how difficult the problems and choices are than to make the decisions easier." She says that in education, health and social services, the main problem was not underfinancing but not knowing what to do. In health, for example, the government set out to help buy medical care for the poor and aged and the effect was to pour new money into the same human and physical resources, with the result, that, "as any student of elementary economics could have predicted, a rapid price increase ensued." Her detailed answer is to design government social programs deliberately as experiments to produce information about what works and what does not work. Intellectually this depends, she concludes, on the development of "performance measures." Analysts ought to concentrate on developing such measures, she says. (RJB)

350. MESTHENE, Emmanuel G. *Harvard University Program on Technology and Society; Fifth Annual Report, 1968-1969.* Harvard Univ. Program on Technology and Society, Cambridge, Mass. 1969. 82 p.

The fifth annual report of Harvard University's Program on Technology and Society describes current research in the Program's major areas of concentration—namely the effects of technological change on the life of the individual in society, social and individual values, the political organization of society, and the structure and processes of social institutions. In the past year interest has shifted towards the first area, the study of the position of the individual in a technological society, with new investigations of work and leisure patterns, and the relationship between psychological character and the changing technical requirements of occupations. Other studies investigate the strain put upon traditional social values by new advances, in particular new biomedical techniques which allow redefinition of traditional concepts such as life, death and human dignity. The anatomy of the categorical negative response to innovation is explored. The appendices contain details about publications, research personnel, teaching activities and the Program's organization. (ERIC/BB)

351. ROGERS, Everett M. and SHOEMAKER, F. Floyd. *Communication of Innovations. A Cross-Cultural Approach.* The Free Press, N.Y. 1971. 476 p.

This book is *the* encyclopedia of research into the diffusion of social innovations. It is a thorough-going revision of Rogers' *Diffusion of Innovations.* 1962. It is based on about 1,500 publications of empirical research, compared to the previous 405, which means that twice as many diffusion researches have been published in the past eight years as in the previous thirty. It is based on many, compared to only a few, investigations in less developed countries; hence the subtitle "A Cross-Cultural Approach." It has integrated research into the diffusion of social innovations with research into human communications, making the former a subset of the latter, and contributing to an understanding of the many steps involved in human communication about

change, particularly where the mass media are involved. "Appendix A, Generalizations About the Diffusion of Innovations" lists each of the more than 100 generalizations grouped by the numbers of the chapters in which they are explained, with citations of studies that support or do not support them. Use of a computer made this possible. The bibliography of the 1,500 publications is complete. The chapters' summaries are models of clarity: e.g., Chapter 7: "A *change agent* is a professional who influences innovation-decisions in a direction deemed desirable by a change agency. The change agent often tills seven roles in the change process: (1) he develops a need for change on the part of his clients, (2)establishes a change relationship with them, (3) diagnoses their problems, (4) creates intent to change in his clients, (5) translates this intent into action, (6) stabilizes change and prevents discontinuances, and (7) achieves a terminal relationship with his clients. . . Change agent success is positively related to: (1) the extent of change agent effort, (2) his client-orientation, rather than change-agency-orientation, (3) the degree to which his program is compatible with clients' needs, (4) the change agent's empathy with clients, (5) his homophily [i.e., similarity in certain attributes] with clients, (6) the extent he works through opinion leaders, (7) his credibility in the eyes of his clients, and (8) his efforts in increasing his clients' ability to evaluate innovations. . .change agent contact is positively related to (1) higher social status among clients, (2) greater social participation, (3) higher education and literacy, and (4) cosmopoliteness." (RJB)

352. BENNIS, Warren G., BENNE, Kenneth, and CHIN, Robert, Editors. *The Planning of Change,* Second Edition. Holt, Rinehart and Winston, Inc., N.Y. 1969. 627 p.

This is the best single-volume survey of the theory and practice of using social technology to help solve the problems of society. It is 43 articles, some of them by the editors, organized into 11 chapters and 4 parts, with introductory texts. Part I focuses on the evolution of planned change, current ideas and their development; Part II deals with the elements of planned change–utilization of scientific knowledge, collaboration and conflict, relevant theories of change, influence and systems in change; Part III deals with the programs and technologies of planned change; and Part IV with the value and goal problems in planned change. The second edition is nine-tenths new readings, it is shorter and has less emphasis upon group dynamics. Managers of institutions and continuing educators will find particularly useful the articles "The Utility of Systems Models and Development Models for Practitioners," by Robert Chin; "Processes of Opinion Change," by Herbert Kelman; and most of Chapter 8, "Instrumentation." (RJB)

353. HAVELOCK, Ronald G. *Planning for Innovation Through Dissemination and Utilization of Knowledge.* Univ. of Michigan. Center for Research on Utilization of Scientific Knowledge (CRUSK), Ann Arbor, Michigan. 1971. 533 p.

Havelock suggests that knowledge utilization, now "a crude art occupying the undivided attention of only a small scattering of scholars in three or four centers of learning," may rapidly become "the science of knowledge utilization." He and his collaborators are among that scattering and CRUSK is one of those centers. This volume is a contribution both to "knowledge building" and to the "institutionalization" of the emergent discipline. It is a report of a project to understand and improve the process of the

dissemination and utilization of knowledge in all fields of practice. Dissemination and Utilization (D & U) is "a transfer of messages by various media between resource systems and users." The process of D & U is interpreted at the levels of the individual, the interpersonal, the organization, and the social system, with attention to "linking roles." "Linkage" is a series of "two-way interaction processes which connect user systems with various resource systems including basic and applied research, development and practice." A major conclusion of the work is, "Senders and receivers can achieve successful linkage only if they exchange messages in a two-way interaction and continuously make the effort to simulate each other's problem-solving behavior." The volume has many diagrams that make explicit processes and relationships. It concludes with implications and recommendations for needed research and development. It has a bibliography of about 700 publications (a more extensive one of about 4,000 items is available from CRUSK under separate cover). This book plus Rogers and Shoemaker's *Communications of Innovations* plus Bennis, Benne and Chin's *The Planning of Change* would make a basic library on social change. (RJB)

354. HAVELOCK, Ronald G. *A Guide to Innovation in Education.* Univ. of Michigan. Center for Research on Utilization of Scientific Knowledge, Ann Arbor, Michigan. 1970. 158 p.

This guidebook to the process of education, written for the change agents of education, deals with new developments in administration, classroom management, curriculum, and teaching methods. It has usefulness beyond the field of education. The author suggests that it may have several important uses on *how* innovation takes place: It provides a conceptual orientation; it gives a checklist; it directs educators to literature and resource persons and organizations; it provides guidelines for problem measurement, evaluation, and diagnosis; it suggests successful strategies used by other innovators in education. Three appendices include a glossary and guide to selection of strategies and tactics, a directory of major information sources in education, and an annotated bibliography of major works on change in education. (MAP)

355. HAVELOCK, Ronald G., HUBER, Janet C. and ZIMMERMAN, Shaindel. *Major Works on Change in Education: An Annotated Bibliography with Author and Subject Indices.* Univ. of Michigan. Center for Research on Utilization of Scientific Knowledge, Ann Arbor, Mich. 1969. 60 p.

This bibliography forms the basis for Havelock's *A Guide to Innovation in Education*, a handbook for education practitioners on planning for change and knowledge utilization. Like the *Guide* its usefulness extends beyond education. The bibliography is directed toward practitioners, researchers, and instructors involved in planned change, innovation, dissemination and knowledge utilization. Selected references meet the following criteria: (1) general coverage of a range of topics relevant to educational change, (2) in book form, which is (3) published and available in education libraries, book stores, or by ordering from indicated sources. (MAP)

356. BECKER, Marshall H. "Factors Affecting Diffusion of Innovations Among Health Professionals". *American Journal of Public Health.* Feb. 1970. Vol. 60, No. 2, pp. 295-303.

This paper summarizes some major results of an extensive research project that traced the patterns by which public health programs diffused among health departments within Michigan, Illinois and New York. The objective was to identify factors that facilitated or inhibited adoption of new programs (measles immunization and topical application of fluoride, for "high adoption potential," and diabetes screening, for "low adoption potential"). The report of the study and findings does not lend itself to abstracting, but in essence, the principles of Everett Rogers *(Diffusion of Innovations)* were both followed and confirmed. The article concludes by answering the question, What can be done to hasten initial adoption of innovation by pioneers? "(1) One crucial step is to ensure that opinion leaders are exposed early to sources of information and influence containing the information necessary to innovate–sources demonstrated by this study to be valued by opinion leaders. . . (2) A second important approach toward speeding up the initial adoption of innovations by pioneers would be to increase the prestige value of proposed innovations and to reduce any risks associated with adopting them. . . (3) It would also seem possible to reduce delays between the adoption of an innovation by a pioneer, by opinion leaders, and by other members of the communication network. This could be accomplished by ensuring that all members of the communication network become informed about the action of the pioneer as soon as possible." (RJB)

357. HAGE, Jerald and DEWAR, Robert. *The Prediction of Organizational Performance: The Case of Program Innovation.* American Sociological Association Annual Meeting. 1971. 38 p. Paper presented Aug. 30-Sept. 2, 1971, Denver, Colo.

Three aspects of organization–structure, resources, and leadership attitudes–were examined in a longitudinal study of 16 health and welfare agencies to determine which factors best predicted the rate of program innovation. Results revealed that occupational specialization was the strongest structural predictor, that professional activity was the most important resource variable, and that positive change attitudes of the elite were the most important leadership variable. (ERIC/RA)

358. KISSICK, William L. "Health-Policy Directions for the 1970's". *New England Journal of Medicine.* June 11, 1970. Vol. 282, No. 24, pp. 1343-1354.

The health endeavor in the United States, a $60,000,000,000 human-services enterprise, is in a state of crisis that challenges the continuation of its pluralistic, independent, voluntary nature. Health care, although still predominantly a private-sector activity, is no longer solely the private concern of the individual. The evolution of the role of the government has proceeded through four phases, beginning with categorical grants-in-aid (1935), investments in the development of health resources (1946), organization and delivery of health services (1963) and a transition to comprehensive health-care systems (1967). Health-policy deliberations during the 1970's including the debates over National Health Insurance, must focus on the modification of financing mechanisms and patterns of organization if society is to realize the most effective utilization of its health resources to provide health care for a population projected to reach 250,000,000 by the end of the decade. (Author)

359. WHITE, Kerr L. "Personal Incentives, Professional Standards, and Public Accountability for Health Care". *Journal of Hospital Governing Boards.* Oct. 1968. Vol. 21, No. 10, pp. 9-15.

White argues that the only way personal incentives, professional standards and public accountability can be harmonized is through the development of "fourth" parties –"multiple health services systems, based on the principles of competition, franchising, regulation and subsidization where necessary. Those persons concerned with preserving opportunities for voluntary initiative in the delivery of health services should set about organizing a wide variety of fourth parties. These organized health services systems could be developed and incorporated by medical societies, hospitals, municipalities and other governmental units, voluntary agencies or public authorities." He sees fourth parties as particularly capable of developing the "process analysis, or the assessment of tissues specimens, laboratory results, x-rays and other procedures, measures and treatments applied to establish a diagnosis or effect improvement in the patient's conditions." The opportunities for building continuing education into such a system of process analysis, he says, are unlimited, "once the assumption is acknowledged that physicians want to do their best work, and once it is recognized that those persons developing systems for assessing process and end results are not engaged in an unrelenting 'rascal hunt.' " (RJB)

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4.4 Obstacles to Improvements

360. NATIONAL HEALTH COUNCIL, INC. *Health Manpower: Adapting in the Seventies.* National Health Council, Inc., N.Y. 1971. 225 p. Report of the 1971 National Health Forum. March 15-17, 1971. San Francisco, Cal.

The National Health Council, founded in 1920, has a membership of over 70 national organizations (voluntary and governmental health agencies, professional and other membership associations, civic and business groups) working to identify and promote solutions for national health problems. The 1971 National Health Forum in San Francisco focused on the occupational and educational barriers which impede the mobility, utilization and distributing of health personnel and obstruct the entry of new personnel. Conference papers include: "Barriers to Manpower Mobility and Utilization" by Hendrik Blum, M.D.; "Legal Regulations of Health Manpower in the 1970's" by Ruth Roemer, J.D.; and "Health Manpower–Adapting in the '70's, Education and Training" by Robert H. Kroepsch, and others. Also included are "showcase demonstrations," or presentations of ways organizations have innovatively dealt with special manpower problems, and a panel discussion of new careerists on their job experiences. (MAP)

361. FREIDSON, Eliot. "Professionalism: The Doctors' Dilemma". *Social Policy.* Jan./Feb. 1971. Vol. 1, No. 5, pp. 35-40.

The author, professor of sociology in the Graduate School of Arts and Science of New York University and Chairman of the Research Committee for Medical Sociology of the International Sociological Association, gives here an uncompromisingly hostile analysis of the "imperialism of professionalism." Although his critique is aimed at all professions, its bull's-eye is the medical profession. The major reason why patients are treated like "objects or like retarded children" is to be found in the professional organization of the hospital, and the solution, he says, requires the involvement of clients in the decision-making and the setting of standards. "The crux of the matter is that expertise is not mere knowledge. It is the practice of knowledge, organized socially and serving as the focus for the practitioner's commitment. The worker develops around his work an ideology and, with the best of intentions, an 'imperialism' that stresses the technical superiority of his work and his capacity to perform it. This 'imperialist' ideology, built into the individual perspective through training and practice, cannot be overcome by ethical dedication to the public interest. The problem arises, however, when outsiders may no longer evaluate the doctor's work by the rules of logic and the knowledge available to all educated men, and when the only legitimate spokesman on an issue relevant to all men must be someone who is officially certified. This is the central policy issue in the provision of such personal services as health care, an issue underlying such concrete questions as how the services are to be paid for and how they are to be presented to the public. The issue is who is to determine what the goals of the service are and the concrete models by which its goals are to be pursued. Accountability for effective and humane services must, in some way, be more responsive to the lay client himself." (RJB)

362. OFFICE OF ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS (DHEW). *Report on Licensure and Related Health Personnel Credentialing.* G.P.O., Washington, D.C. June 1971. 154 p.

This discusses the major problems connected with licensure, certification and accreditation for practice or employment of health personnel (including group practice of health personnel). It also identifies the activities of Federal agencies and professional organizations that are examining these problems and working toward solutions to the health manpower shortage. HEW Secretary Eliot Richardson makes specific recommendations. Topics examined include: the interaction between the licensing process and professional organizations, the special problems of foreign graduates, the influence of licensure on mobility, the demonstration and maintenance of proficiency, and approaches to institutional licensing. Appendices include material on physician's assistants; information on 16 selected health occupations (regarding manpower, professional associations, certification or registration of individuals by nongovernment agencies, accreditation of educational programs, state licensure); and information on licensure, accreditation and certification (e.g., the health occupations licensed in each state, the associations recognized for their specialized accreditation of health educational programs, and designation of certification or registration of health manpower by nongovernmental agencies). (MAP)

363. SELDEN, William K., Director. *Study of Accreditation of Selected Health Educational Programs*(SASHEP). *Part I and Part II: Staff Working Papers, and Commission Report.* The National Commission on Accrediting, Washington, D.C. 1971-72.

This study was co-sponsored by the American Medical Association, the Association of Schools of Allied Health Professions, and the National Commission on Accrediting and funded by the Commonwealth Fund. SASHEP's purpose was to find the means to promote collaboration between professional associations in allied health and educational institutions in these fields to create a new system of accreditation that will make possible a coherent, flexible, and rational approach to manpower development. The staff developed two volumes of working papers: Part I (October 1971) dealing with structure, finance, research, and expansion as they relate to the accreditation of health education programs: and Part II (February 1972) dealing with some of the major problems in accreditation, an approach, and some of the practices to be pursued in accreditation, and its relationship to voluntary certification and state licensure. The Report (May 1972) summarizes the basic issues and problems, codifies basic policies for accreditation, and offers conclusions and recommendations. Its major recommendation is that an independent, broadly representative organization—the Council on Accreditation for Allied Health Education—be established, made up of practicing physicians, practicing allied health professionals, educators, and representatives of institutional employers and of the federal government. (MAP)

364. CARLSON, Rick J. "Health Manpower Licensing and Emerging Institutional Responsibility for the Quality of Care". *Law and Contemporary Problems.* Autumn 1970. Vol. 35, No. 4, pp. 849-878. From the Symposium on "Health Care: Part II".

The author, research attorney, Institute for Interdisciplinary Studies, Minneapolis, is concerned with the "general reluctance of the health-care establishment to act affirmatively for change," and he reviews all the major factors (organization, capacity, financing, structure, distribution), but the focus of his argument is on the necessity for reform of the licensure system for health professionals. After a review that is both wide-ranging and precise, he considers proposals—maintenance of the status quo, expanding the licensure scheme, certification of paramedicals, enactment of specific and general delegatory statutes, the establishment of a health manpower committee or board, and investing institutions with licensure authority—and he finds them all inadequate. He then concludes with his new proposal: ". . .that statutory licensure laws be amended to repeal licensure restrictions for all health care practitioners other than the physician when such practitioners are employed by health-care organizations registered to do business in the state and licensed to provide health care. All practitioners not employed by health-care organizations should be required to obtain certificates of practice from a health manpower board consisting of representatives of health professions, with a majority of nonprofessional representation. Physician licensure should be retained for all physicians who are not affiliated with such organizations until such time as geographic mobility would not be impeded by unlicensed status. Physician licensure should then be abolished and replaced by a registry scheme administered by a state health manpower board. Health-care organizations would agree to submit to the process and jurisdiction of the state courts as a condition of licensure and would further agree to participate in a statutory compensation system for medical injuries when such a system is developed." (RJB)

365. MEDICAL COLLEGE OF VIRGINIA. *Law Institute on Hospitals and Medicine.* Prepared and Published by Continuing Education Department, School of Hospital

Administration, and Department of Legal Medicine, School of Medicine, Medical College of Virginia, Virginia Commonwealth University, Richmond, Va. 1971. 193 p.

This is probably the best single compendium of laws and court decisions concerning liability of hospitals and other health-care institutions and of doctors and other health-care practitioners. The first part includes articles by Arthur Southwick, "Hospital's Vicarious Liability"; Irving Kaminsky, "Hospital Liability for Private Duty Nurses, Volunteers and Physician's Assistants"; Betty J. Anderson, "Licensure of Paramedical Personnel"; Jack B. Russell, "Hospital Liability Insurance and Paramedical Personnel." The second part, *The Best of Hospital Law-1970*, is made up of articles by Roger Copenhaver, Jr., "Medical Legal Aspects of Artificial Insemination"; Robert W. Jackson, "Liability and the Mental Patient"; F. Dee Goldberg, "Suicide and Physician Liability"; Thomas P. O'Neal, "Homosexual Acts Related to Hospitals"; William A. Burns, "Rubella and Abortion Laws"; and Thomas D. Jordan, "Legal Aspects of Nursing Services." (RJB)

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4.5 Cooperative Planning for Health Care

366. WAGNER, Carruth J. "A Systems Approach to Health Planning." *Planning for Health: Report on the 1967 National Health Forum.* National Health Forum, Chicago, Ill. 1967.

The author suggests a method of planning that will permit the integration of health programming into the total planning for community improvement, embracing the modern concepts of health that encompass the total wellbeing of the individual as he grows and matures. Wagner presents a kind of model—"the steps or schema of comprehensive health planning"—developed by the Bureau of Health Services of the Public Health Service, which he thinks embodies a "general approach which appears to be applicable in part, if not in total, to comprehensive health program planning at other levels, by either governmental or nongovernmental agencies and organizations." (RJB)

367. AMERICAN HOSPITAL ASSOCIATION. *Relationship Among Health Care Facilities.* American Hospital Association, Chicago, Ill. 1965. 30 p.

This is the report of a workshop held in Chicago July 21-23, 1964 co-sponsored by the American Association of Homes for the Aged, the American Hospital Association, Blue Cross Association, and the U.S. Public Health Service. Earlier workshops considered the relationships between hospitals and nursing homes and between hospitals and homes for the aged. This workshop dealt with the relationships among all types of health facilities and agencies. Participants explored ways of stimulating effective working relationships among health-care institutions, and the roles of local, state, and

national associations representing the institutions, professions, and health and welfare organizations in making these relationships workable. Several themes emerged: Responsibility and planning should be communitywide; there is a need for a community coordinator or "catalyst"; there should be better communication among institutions; there is no adequate financing mechanism to cover the cost either of long-term inpatient care or of home care; there should be an accreditation program for nonhospital facilities, similar to the program of the Joint Commission on Accreditation of Hospitals. (MAP)

368. AMERICAN HOSPITAL ASSOCIATION. *Invitational Conference on Comprehensive Health Planning.* American Hospital Association, Chicago, Ill. 1969. 70 p.

The American Hospital Association held an Invitational Conference on Comprehensive Health Planning in Chicago on October 24-25, 1968. The papers, panel discussions and group reports of this conference explored how the Comprehensive Health Planning program, as it relates to hospitals, might be implemented most effectively, recognizing that hospitals were involved in only one part of the total Comprehensive Health Planning programs and that health is only one of the many areas included in national comprehensive evaluation and planning. (RJB)

369. BROWN, Douglas R. *The Areawide Hospital Planning Process.* Cornell Univ., Ithaca, N.Y. 1971. 286 p.

This study is the result of visits to 30 hospitals and health facility planning councils in 1967. Seventy-five planners, including 12 board members and all 30 executive directors of the institutions visited were asked open-ended questions. The work was the basis of a doctoral dissertation *(The Health Planning Process, A Study of Areawide Hospital and Health Facility Planning Agencies in the United States)* submitted to Syracuse University in 1968. Part I sets out the major characteristics of the areawide endeavor, Part II deals with structural and organizational considerations, and Part III analyzes the roles and views of the planners and summarizes. The main conclusion is that hospital planning at the areawide level evolves as a process with businessmen, industrialists, health-care providers and council planners working together for purposes both of self-interest and health-service development. (MAP)

370. VOGT, Paul J. "Ambulatory Care: Most Programs Inadequate". *Hospitals.* Dec. 16, 1971. pp. 59-61.

Vogt, director of Health and Hospitals for the County of Hennepin, Minnesota, judges that outpatient departments of most large hospitals are merely stop-gap, episodic, substitute medical care centers. He says that, if a health-care institution is to provide comprehensive ambulatory care, then organizational change is required, which in turn requires attitudinal change on the part of the staff. As an example, he describes his experience in Hennepin County, which includes Minneapolis. In addition to better ambulatory care, Vogt calls for an awareness of health processes, preventive measures, an integrated medical-record system, and an interweaving of comprehensive care with acute, intermediate, long-term, and home-care programs. Community participation, especially in neighborhood health centers and primary care, is important, he says. For organization changes to be made, there must be commitment to the total delivery system by those in authority and present

organizations must be re examined to see whether they fit the management needs of a comprehensive health-care system. The author contends that the hospital, in cooperation with other appropriate agencies, must develop community-wide ambulatory services, and primary-care centers; the hospital must organize itself for manpower development and back-up facilities for primary-care services. (MAP)

371. ROSENFELD, Leonard S. *Ambulatory Care: Planning and Organization.* Health and Hospital Planning Council of Southern New York, Inc., N.Y. 1971. 569 p.

The study documents and analyzes the origins and current status of planning, organization, and administration of ambulatory care facilities and services. It is based on a literature review of medical care and related fields of public health and the social sciences and on observation of selected programs, with particular emphasis on statistical and accounting systems. The study provides assistance to those responsible for planning, organization, and administration of ambulatory care facilities. (NTIS/Author)

372. OAKES, Charles G., Editor. *Functional Elements of Outpatient Care–A Survey of Practical Approaches.* Converse College, Spartanburg, S.C. 1971. 42 p.

This volume represents the proceedings of an August 1970 conference jointly sponsored by Converse College and the South Carolina Hospital Association. The purpose of the conference was to inform specialists in the delivery of health care of the emerging role of outpatient or ambulatory services as a supplement to hospital inpatient services and to the private or group practices of physicians. The booklet is a collection of four papers, each representing a different viewpoint written from the perspective of a physician, a nurse, a medical sociologist, and a hospital administrator. (JAHA)

373. HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION. Health Care Facilities Service (DHEW). *Hospital Outpatient Emergency Activities: Functional Programming Guidelines.* G.P.O., Washington, D.C. 1971. 48 p.

This document offers comprehensive guidelines to help hospital planners identify the specific program elements required in a given situation. It shows planners the necessity of considering the service element, the supportive resources, priorities among elements, and future program needs. Because hospital services differ, no model is offered. The authors intend the suggested activites to be "thought-starters and reminders" for program planning. They include also worksheet questions for outpatient activities and emergency activities. (MAP)

374. AMERICAN HOSPITAL ASSOCIATION. *Emergency Services: The Hospital Emergency Department in an Emergency Care System* Revised Edition. American Hospital Association, Chicago, Ill. 1972. 98 p.

This manual–an exhaustive revision of the 1966 edition–covers general principles for planning, developing, and evaluating an emergency department and for setting policies and procedures. It discusses emergency services in the light of new needs and objectives, including communitywide and regional planning. It deals with supervision, staffing, physical requirements, legal questions, proposals for improved service, and many other practical considera-

tions. The manual includes an extensive bibliography, lists of equipment and supplies, checklists for facility analysis, and other supplementary material. (JAHA)

375. HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION (DHEW). *Emergency Health Services Selected Bibliography.* G.P.O., Washington, D.C. 1970. 165 p.

This annotated bibliography contains books, journal articles, visual aids, and other documents pertaining to emergency health care, which are organized according to (1) publications dealing with day-to-day health emergencies that occur at home, work, and play, (2) documents that will help communities prepare for emergencies, including natural disasters and nuclear war, (3) films and slides on disaster care and training kits for medical self-help, and (4) sources of catalogs, bibliographies, and publication lists that include material on disaster care and day-to-day emergencies. Listed alphabetically by title, each entry contains: (1) a title number, keyed to a subject index, (2) a publication number if known, (3) name of producer, author, or editor, (4) publisher, date of publication, and number of pages, (5) availability of free copies or sales stock, (6) brief annotation, (7) intended user audience, and (8) name and address of the publication's source. A listing on non-government and government sources is appended. (ERIC/SB)

376. VANCE, Mary, Editor. *Planning for Locational Change in the Delivery of Medical Care: A Selected Bibliography.* Council of Planning Librarians, Exchange Bibliography 100, Monticello, Ill. Oct. 1969. 11 p.

377. VANCE, Mary, Editor. *Bibliography of Periodicals for the Health Planner.* Council of Planning Librarians, Exchange Bibliography 102, Monticello, Ill. Oct. 1969. 9 p.

378. HILLEBOE, Herman E. and SCHAEFER, Morris. *Papers and Bibliography on Community Health Planning.* State University of New York at Albany, Graduate School of Public Affairs, Albany, N.Y. 1967. 81 p.

This provides a rationale for health planning and suggests ways to improve it. The first paper points out obstacles and describes a method of orderly assignment of roles as a remedy. The second paper suggests approaches to health problems by grouping them into "problem areas." The third paper is a guide for a systematic approach to health resources development. The last section is a comprehensive bibliography (1964-66) obtained by a NLM computer search. (MAP)

379. BLACKMAN, Allan *A Bibliography of Bibliographies on Comprehensive Planning for Health and Related Topics.* Association of University Programs in Hospital Administration, Washington, D.C. July 1970. 32 p.

This publication was produced under a grant from the Office of Comprehensive Health Planning, Department of Health, Education and Welfare. It recognizes that there is no single regular abstracting service covering all literature of interest to planners. The bibliography is directed in particular to those without a library degree and to those persons operating a small urban study or planning agency library on a part-time basis. Topics include health

planning, economics of health, emergency-care services, health and goals definitions, hospital planning, manpower, and the sociology of medicine. (MAP)

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4.6 Citizen Participation

380. BURKE, Edmund M. "Citizen Participation Strategies". *American Institute of Planners Journal.* Sept. 1968. pp. 287-294.

The author, chairman of Community Organization and Social Planning at the Boston College Graduate School of Social Work, says the view that "citizen participation" is self-evidently practicable has to be discarded. "Planning agencies must be more precise about what they mean by citizen participation, how they intend to implement it, what agency resources will be used to organize and involve citizens, and what voice citizens will have in planning decisions." He says there are basic conflicts between participatory democracy and professional expertise. Some, but perhaps not all, of the conflicts can be resolved by recognizing and adopting a strategy of participation specifically designed to fit the role and resources of the particular organization. He then analyzes citizen participation "not as a value, but as the basis for various strategies." He identifies and defines five: (1) *Education-therapy strategy*–the end is improvement of the individual participants, not the accomplishment of a task; (2) *Behavioral-change strategy*–the orientation is deliberately to bring about certain changes by influencing individual behavior through group membership; (3) *Staff-supplement strategy*–the recruitment of citizens to carry out tasks for an organization which does not have the staff resources to carry them out itself; (4) *Co-option*–to involve citizens in an organization in order to prevent anticipated obstructionism; and (5) *Community-power strategies*–to confront existing power centers with the power of an organized and committed mass of citizenry. Burke ends with a brief consideration of which strategies are best suited to which conditions and objectives, but his main point is to call attention to the need for clear thinking about citizen participation. (RJB)

381. ROGATZ, Peter and ROGATZ, Marge. "Role for the Consumer". *Social Policy.* Jan./Feb. 1971. pp. 52-56.

The authors describe the factors and conditions that until recently have limited the opportunities for consumers to play a meaningful role in the development of national policy for health care. They doubt that the newly established statewide and regional comprehensive health planning agencies will open a new channel for changing policy because ". . .simply mandating a technical majority of consumers offers no assurance that the decision-making process will not continue to be dominated. . .by professionals." The authors see interaction on the local level as having the greatest possibilities for consumer direction. Consumers must participate both in planning health-care programs and in providing health care themselves as paraprofessionals. The

authors call for a reasonable balance between professionals and consumers, and suggest that a patient-advocate or ombudsman will be needed until there is enough consumer input. (MAP)

382. CITIZENS BOARD OF INQUIRY INTO HEALTH SERVICES FOR AMERICANS. *Heal Yourself.* Univ. of North Carolina, Chapel Hill, N.C. 1971. 92 p.

This is a report of a broadly representative board of consumers and health providers who studied America's health services from the viewpoint of the consumer. The board talked to as many providers and users of health care services in this country as was possible during its inquiry. The report describes the feelings of people about the delivery of health services and about health providers; the opportunities of consumers actually and effectively to participate in planning and operating health care systems; and attempts to change the system by the use of other models of health care. The conclusions and recommendations clearly and concisely call for a full partnership role by the consumer in planning, organizing, and delivering health care. Each chapter has extensive footnotes which provide a rich bibliography of medical-care reading. (AJN)

383. BOOTHE, William, BEETHAM, Mary Alice and STRAUSS, Marvin. *Bibliography: Consumer Participation in Comprehensive Health Planning.* Council of Planning Librarians, Monticello, Ill. March, 1969. 7 p. Exchange Bibliography #72.

This bibliography was prepared for a workshop on "Consumer Participation in Comprehensive Health Planning," February 10-12, 1969, Cincinnati, sponsored by the Graduate Department of Community Planning, University of Cincinnati, and the Ohio Chapter, Society of Public Health Educators. Citations deal broadly with community action programs, citizen participation, the politics of change, power structures, organizational planning and design. (MAP)

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4.7 Financing

384. MILLIS, John S. *A Rational Public Policy for Medical Education and Its Financing.* National Fund for Medical Education, Cleveland, Ohio. 1971. 166 p.

During the past five years, the National Fund for Medical Education, under the direction of John S. Millis, has viewed with concern the deepening crisis in medical eduation. The purpose of this book is to inform people of the need for a change in policy that the crisis might be alleviated. Chapter 1 deals with public policy and medical education and includes a history of the role of the public in changing the system. Chapter 2 explores the quantitative dimensions of medical education regarding education, research, and patient care. Chapter 3 defines the purpose of medical education with expositions on medical cure and health care, successes and failures in the worlds of medical cure and health care, the role of research, and the numerical need for physicians.

Chapter 4 deals with the process of medical education with sections on classical medical education, the beginnings of change, and the changes measured against objectives. Chapter 5 discusses the mechanism of medical education including the medical center role, the discontinuity of graduate education, and the factor of faculty to student ratio. Chapter 6 then proposes a policy for financing it. Finally chapter 8 deals with the priorities for action. (ERIC/HS)

385. ROEMER, Milton I., DuBOIS, Donald M. and RICH, Shirley W., Editors. *Health Insurance Plans: Studies in Organizational Diversity.* Univ. of California. School of Public Health, Los Angeles, Cal. 1970. 449 p.

In the United States, there are six forms of insurance for physician's care: three forms of sponsorship (consumers or their employers, providers of services, and commercial insurance organizations) compounded with two patterns of medical practice (solo practitioners and group practice clinics). The full meaning and the operational implications of each of the six types constitute the principal body of this book. The data are drawn from the California scene because, Dr. Roemer states, "patterns of health insurance found anywhere in the nation are found also in California–plus certain patterns not found elsewhere." The 23 papers were prepared by members of the academic staff of the division of health administration of the UCLA School of Public Health as part of a long-term research project supported by the U.S. Public Health Service. The book consists of five parts: background information, health insurance plans based on free choice of solo practitioner, plans based on group medical practice, some outcomes of health insurance, and medical care prospects. (JAHA)

386. REED, Louis S. *Health Insurance Plans Other than Blue Cross or Blue Shield Plans Or Insurance Companies: 1970 Survey.* Social Security Administration. Office of Research and Statistics (DHEW), Washington, D.C. 1971. 119 p. Research Report No. 35.

This gives the findings of a survey conducted in 1969 by the Office of Research and Statistics of the Social Security Administration of all private health insurance plans other than those of Blue Cross, Blue Shield, or insurance companies. Such surveys have been conducted since 1944 and the last full survey was in 1965 to obtain data for 1964. The Office of Research and Statistics is the only source of comprehensive national information on the number of persons served by these organizations, the services and benefits provided, and their income and benefit and operating expenses. The report classifies the plans into seven main types: (1) community-group practice; (2) community-individual practice; (3) employer-employee union group practice; (4) employer-employee individual practice; (5) private group medical clinic; (6) private group dental clinic; and (7) dental service corporation. (MAP)

387. HANEY ASSOCIATES. *The Health Funds Directory.* Haney Associates, Inc., and Health Funds Institutes, Concord, Mass. 1970. 3 Volumes.

The directory is a comprehensive source of information on all Federal funding programs for health-related purposes. The Department of Health, Education, and Welfare provides a large portion of such aid, but HEW is not the only funding agency. The directory gives needed information on the pertinent programs of all Federal departments, officers, bureaus, and agencies--from the Atomic Energy Commission to the Small Business Administration. The write-up on each Federal aid program contains, whenever possible, the following sections: general program description, type of aid available, financing, funding, eligibility requirements, priorities in funding, application procedures and information, publications and descriptive brochures available, authorizing legislation, and administering agency. The directory is published in three loose-leaf volumes, composed of seven separate sections: introduction and outline of contents, Federal programs table of contents, research, education and training, facility improvement and construction, miscellaneous, and appendixes and address lists. Supplements that update and expand directory materials are published annually. (JAHA)

388. NATIONAL INSTITUTES OF HEALTH. National Library of Medicine (DHEW). *Governmental Role in Financing the Delivery of Health Care in the U.S.* National Library of Medicine, Bethesda, Md. 1971. 14 p. Literature Search No. 71-18. Jan. 1969-June 1971.

This is a reprint of one of the NLM's selected, computer-generated bibliographies produced by the Library's Medical Literature Analysis and Retrieval System (MEDLARS). It contains a major portion of the relevant citations appearing in *Index Medicus* between the dates shown. Each citation is listed together with the descriptors selected from the Library's list of medical subject headings (MeSH). A complete list of Literature Search titles can be obtained by writing: Literature Search Program, Reference Section, Reference Services Division, National Library of Medicine, 8600 Rockville Pike, Bethesda, Md. 20014. (MAP)

389. NATIONAL INSTITUTES OF HEALTH. National Library of Medicine (DHEW). *Government Role in Financing the Delivery of Dental Care in the U.S.* National Library of Medicine, Bethesda, Md. 1971. 4 p. Literature Search No. 71-19. Jan. 1969-June 1971.

This is a reprint of one of the NLM's selected, computer-generated bibliographies produced by the Library's Medical Literature Analysis and Retrieval System (MEDLARS). The reprint contains a major portion of the relevant citations appearing in *Index Medicus* between the dates shown. Each citation is listed together with the descriptors selected from the Library's list of medical subject headings (MeSH). A complete list of Literature Search titles can be obtained by writing: Literature Search Program, Reference Section, Reference Services Division, National Library of Medicine, 8600 Rockville Pike, Bethesda, Md. 20014. (MAP)

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4.8 The Regional Approach

390. BODENHEIMER, Thomas S. "Regional Medical Programs: No Road to Regionalization." *Medical Care Review.* Dec. 1969. pp. 1125-1157.

The author gives a history of regional attempts to improve health care in the United States since 1932, makes a theoretical analysis of the concept of regionalization, and discusses the difficulties of regionalizing American health services. His analysis should prove helpful on the evaluation of past Regional Medical Programs and in the planning of the next attempt. The article has 21 references, which together add up to a brief bibliography of the history and the critiques of the several attempts at regionalization. (RJB)

391. KOMAROFF, ANTHONY L. "Regional Medical Programs in Search of a Mission". *New England Journal of Medicine.* April 8, 1971. Vol. 284, No. 14, pp. 758-764.

"... confusion exists over the mission of the Regional Medical Programs, and the means by which to achieve that mission. Particularly at issue is their role in changing, rather than simply upgrading the existing health-care delivery system. It remains to be seen whether they are faced with a golden opportunity or an insoluble dilemma." (NEJM)

392. McNERNEY, Walter J. and others. *Regionalization and Rural Health Care: An Experiment in Three Communities.* The University of Michigan, Ann Arbor, Mich. 1962. 209 p.

This is the report of a study undertaken by the Bureau of Hospital Administration, Graduate School of Business Administration, the University of Michigan, to examine a regionalization compact entered into by three health centers and two regional hospitals in rural northern Michigan. At the end of the first decade (1962), the three centers of the W.K. Kellogg Foundation-aided program were still in existence, but the concept of regionalization did not survive. The authors examine the factors affecting the success and failure of regionalization as a help to other hospital administrators contemplating the development of regional patterns. They do this by discussing the regional concept, rural community action, health center operation, the extent of regional relationships, attitudes toward regional affiliation, utilization in the three communities, and the community viewpoint toward the health centers and health care. (MAP)

393. NATIONAL INSTITUTES OF HEALTH. Bureau of Health Manpower Education. *Area Health Education Centers.* National Institutes of Health, DHEW, Washington, D.C. 1972.

This brochure of "Contract Support for Operation of Area Health Education Centers" explains a program for the development and support of Area Health

Education Centers implemented under Section 774A of the Comprehensive Health Manpower Training Act of 1971. Schools of medicine and osteopathy are invited to submit a letter of intent for the development of such centers. An AHEC "has as its nucleus a public or nonprofit hospital, usually a community hospital, or a consortium of hospitals. It is located at some distance from a medical center, and has a written agreement with the medical center which provides for the effective control by the medical center of specified educational programs conducted in the hospital." In addition to providing outpatient and inpatient medical services and servicing as a referral center for other patient-care facilities, the AHEC conducts the following educational programs: (1) continuing education for physicians and other health practitioners in the area; (2) residency training programs, and also clinical instruction for medical and other undergraduate professional students- e.g., dentistry, allied health or nursing; (3) assistance to educational institutions and health-care facilities in the area in the development of training programs for health personnel. A medical center may be linked with one or more Area Health Education Centers. However, each AHEC must have a well-defined geographical area which it will serve. There will be only one HEC for each area. The area served does not have to correspond with State or local jurisdictions. Additional information may be obtained from Manpower Initiative Program, Office of Special Programs, Bureau of Health Manpower Education, National Institutes of Health, 9000 Rockville Pike, Bethesda, Md 20014. (See Item No. 406.) (RJB)

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4.9 Health Maintenance Organizations

394. GARFIELD, Sidney R. "The Delivery of Health Care". *Scientific American*. April 1970. pp. 15-23.

The originator of the Kaiser-Permanente plan proposes a new health-care delivery system. The Kaiser-Permanente program alters the traditional delivery system in only two ways: It eliminates the fee for service, substituting prepayment, and it organizes the many units of medical-care resources into a coordinated group practice in integrated clinic and hospital facilities. The elimination of the fee required a "new regulator. . .at the point of entry, one that is more sensitive to real medical need than to ability to pay and that can help to separate the well from the sick and establish entry priorities for the sick. We believe we have developed just such a regulator"—health testing, also called multiphasic screening, or health evaluation. "As a new entry regulator, health testing serves to separate the well from the sick and to establish entry priorities. In addition it detects symptomless and early illness, provides a preliminary survey for the doctors, aids in the diagnostic process, provides a basic health profile for future reference, saves the doctor (and patient) time and visits, saves hospital days for diagnostic work and makes possible the maximum utilization of paramedical personnel. Most important of all, it falls into place as the heart of a new and rational medical-care delivery system."

After health testing the patient would be referred for sick care, health care or preventive maintenance as required and would be transferred among the services as his condition changed. The computer center would regulate the flow of patients and information among the units, coordinating the entire system, which would depend heavily on paramedical personnel to save doctors' time. The sick-care center would be staffed by physicians, with paramedical assistance. The health-testing and referral service, the health-care center and the preventive-maintenance service would all have paramedical staff under medical supervision. (RJB)

395. CONGRESS OF THE U.S. SENATE COMMITTEE ON FINANCE. *Health Maintenance Organizations:* Staff Questions with Responses of the Department of Health, Education, and Welfare. G.P.O., Washington, D.C. 1971. 23 p.

"HMO is a generic term, encompassing a variety of organizational structures and approaches which have in common the combination of financing and delivery mechanisms so that both consumers and providers have a stake in maintaining health and, when services are required, in assuring the most efficient and effective use of available facilities and services." In answering 34 questions posed by the staff of the Finance Committee, the Department of HEW reviewed its policies concerning HMOs as of September 1971, when that approach was "a major and significant part of the . . . efforts to develop possible solutions to health care problems." A four-page appendix compares HMO provisions in various bills. (RJB)

396. UNIVERSITY OF CHICAGO. *Health Maintenance Organization: A Reconfiguration of the Health Services System.* Univ. of Chicago. Graduate Program in Hospital Administration, Chicago, Ill. 1971. 90 p. Proceedings of the Thirteenth Annual Symposium on Hospital Affairs, May 1971.

The 13th Annual Symposium on Hospital Affairs was held in May 1971. This publication contains the transcripts of the papers presented at this symposium. Topics covered are: "Will the Health Maintenance Strategy Work?", "Analysis of the HMO Proposal," "Start-up Problems of HMOs," and "Implementation of the HMO Concept." (JAHA)

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4.10 Improvement Through Better Management

397. NEUHOUSER, Duncan. *The Relationship Between Administrative Activities and Hospital Performance.* Univ. of Chicago, Center for Health Administration Studies, Chicago, Ill. 1971. 115 p. Research Series No. 28.

This research project was probably the first empirical attempt to see what effect different hospital management techniques have on costs and quality of care. The results show that differences in management make a predictable and significant impact on hospital performances. The weight of the evidence

supports the "Entrepreneurial Theory" that "specification of procedures is positively related to efficiency only in those areas with the lowest level of complexity" (the non-medical areas); specification of procedures "is negatively related to efficiency and participatory management techniques are more appropriate" in high complexity areas (the medical areas); and "visibility of consequences and use of reports are positively related to efficiency for both the medical and non-medical components." The reports states implications of these findings for hospital trustees and administrators, the medical staff, and the Joint Commission on Accreditation of Hospitals. One implication is that the "JCAH might expand its role of increasing visibility of consequences by providing the medical staff and hospital management with basic information on their comparative performance." Another is that trustees who are indifferent to or unaware of their hospital's real performance "provide no incentive for the administration and medical staff to improve performance." A third implication is that "externally generated managerial techniques. . .do not have the impact on performance that internally generated management techniques do." (RJB)

398. GEORGOPOULOS, Basil S., Editor. *Organization Research on Health Institutions.* Univ. of Michigan. Institute for Social Research, Ann Arbor, Mich. 1972. 418 p.

The concern leading to this volume is both for more effective and efficient health-care delivery and for theoretical understanding of organization in the health-care field. This volume, focusing on the hospital, is a critical review of recent social-psychological research on hospital organization and current thinking about the health-care field, and an attempt to make a partial synthesis. It is the end result of a two-day research conference held at the Institute for Social Research in May 1970. The conference was part of a research project aimed at appraising the state of dependable knowledge in the area–Research Contract No. HSM 110-69-207 between the Public Health Service and the Institute for Social Research. Basil S. Georgopoulos, Ph.D., of the University of Michigan, editor of the volume, is director of the project. A key thought concludes Chapter 15, "The Hospital Administrator and Organizational Effectiveness," by Anthony R. Kavner, Ph.D., University of Pennsylvania: "The administrator. . .is for many hospitals the person most qualified and most likely to act as change agent. And yet if (he) is to be increasingly held accountable for hospital effectiveness he must also be able to hold program and subunit heads, including doctors, similarly accountable. . . The administrator's expertise is that of an integrator structuring the perceptions among producers, and between producers and consumers, so that change can be effected without destroying organizational integration. With appropriate authority. . .administrators can be held far more closely accountable for poor results as well as good ones." Bibliographies follow each of the substantive chapters. There are introductions, comments and appendices. (RJB)

399. FERRER, H.P., Editor *Administration, Research and Management.* Butterworths, London, England. 1972. 379 p.

Increasing pressure to apply management techniques in the health services is bound to lead to more interest in management methods. This textbook aims to satisfy this interest. It covers a wide range of topics, each by a specialist author: from the present and future administrative structure of the services,

to the role of the community physician; from simple statistical analysis, to fairly sophisticated operational research models; and from some practical problems of nursing administration, to a review of research in organizational structure and behavior. There is also a large section on financial management, health services costing, and accounting. The authors succeed in raising some issues as well as providing elementary information about what may be new concepts to some readers. This primer will help many people to find out what medical management is all about. (LANCET)

400. GREENBLATT, Milton, SHARAF, Myron R. and STONE, Evelyn M. *Dynamics of Institutional Change: The Hospital in Transition.* Univ. of Pittsburgh Press, Pittsburgh, Pa. 1971. 260 p.

This book consists of three parts. The first, "Concept and Techniques of Change," describes the social dynamics involved when a new administrator takes over an old institution. The presentation is from the view of the administrator and how he conceives of the crisis situations that develop when new management changes the emphasis of treatment. The solutions to these problems within the hospital are also described. The second part, called "Special Services," is a continuation of the first, but involves problems around specific service areas. Examples used are creation of an adolescent program and changes in the rehabilitation and volunteer services. The third part is a discussion of education and research and is also closely linked to the first two parts. (NEJM)

401. TIBBITTS, Samuel J. "Health Care Delivery: Improvements Through Management." *Hospitals.* Sept. 16, 1971. pp. 47-49.

Tibbits, president of the Lutheran Hospital Society of Southern California, asks if it is really necessary to implement a radical philosophical change in our health-care system. He advocates a systematic management approach designed to correct the weaknesses (fragmentation, waste, lack of comprehensiveness, spotty delivery of care). He emphasizes the need for research and development in the management of health-care facilities and the health system. He writes that present techniques, such as systems engineering, industrial engineering, planning, computerization, etc., can be used in the health field. The administrator prefers a system that is pluralistic and voluntary (as opposed to compulsory government health programs) and discusses the American Hospital Association's Ameriplan as a proposal which fulfills both these attributes. (MAP)

402. BATTISTELLA, Roger M. and WEIL, Thomas P. *Health Care Organization: Bibliography and Guidebook.* Association of University Programs in Hospital Administration, Washington, D.C. April 1971. 118 p.

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4.11 Assessing Cost-Benefit

403. KLARMAN, Herbert E. "Present Status of Cost-Benefit Analysis in the Health Field". *American Journal of Public Health.* Nov., 1967. Vol. 57, No. 11, pp. 1948-1953.

The author, professor of public health administration and political economy, Johns Hopkins University, begins with the a, b, c's: "Essentially cost-benefit analysis entails a comparison of costs and benefits for a series of programs thought of as alternatives or competitors for public funds." He describes some of the difficulties in applying cost-benefit measurements outside the market economy. Nevertheless, he thinks that the way to advance is to continue-to further dialogues between economists and health practitioners, such as doctors. For all its shortcomings at this stage, cost-benefit analyses clarifies thinking and helps define problems and alternative approaches. "The tasks ahead appear to be as follows: (1) To try to calculate both the costs and benefits of specific programs, always looking ahead and looking out for side effects. We shall learn the technique by doing. (2) To formulate the problems in a manner that will clearly point to the kinds of data required, and to ask for the compilation of data where they do not now exist. (3) To enlist the efforts of investigators and program analysts from various disciplines to help develop and bring to bear the methods of measurement and analysis required. (4) To continue to strive for good judgment in making decisions when major elements of the cost-benefit calculation are missing, as they frequently are." (RJB)

404. GROSSE, Robert N. "Cost-Benefit Analysis of Health Service." *Annals of the American Academy of Political and Social Sciences.* Jan. 1972. pp. 89-99.

"Where my health is concerned, cost is no object." The reply of the penniless man to an expensive specialist reflects a moral question. Should the costs of health services be a significant consideration in deciding upon governmental health policies and programs? The answer in my opinion is yes. Costs ought to be used in deciding the level of health activities versus other social goods and services, and in planning which health programs to support. The truly moral problem is not to distinguish between good and evil but rather to select appropriately among alternative goods. After arguing that consideration of cost is a moral imperative, the usefulness of cost-benefit analysis in framing the right questions and in improving the chances of moving in directions of social improvement is urged, and some limitations are noted. Finally, examples of the use of cost-effectiveness analysis in studying problems of disease control and maternal and child health are given. (Author)

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4.12 Increasing Supply of Health Manpower

405. GRUPENHOFF, John T. and STRICKLAND, Stephen P., Editors. *Federal Laws: Health/Environment Manpower.* The Science and Health Communications Group, Washington, D.C. 1972. 392 p.

This comprehensive source book deals with health manpower resources and the Federal government's role in insuring adequate numbers of health professionals. The editors and contributors regard the passage of the Comprehensive Health Manpower Training Act of 1971 and the Nurse Training Act of 1971 as climactic points in the last decade's health manpower legislation, and, as the government's first explicit decision to increase the number of physicians. In addition to these two Acts, discussion include: Federal support for health-manpower development; allied-health and public-health training programs; Veterans Administration health-manpower training, and environmental-manpower training and environmental education. The appendices are nearly 200 pages of basic source documents, including the President's 1971 Message to Congress on Health, reprints of important legislation, and excerpts from Congressional committee reports on pending legislation. (MAP)

406. THE CARNEGIE COMMISSION ON HIGHER EDUCATION. *Higher Education and the Nation's Health: Policies for Medical and Dental Education.* McGraw-Hill Book Co., N.Y. 1970. 129 p.

This report "is concerned with the serious shortage of professional health manpower, the need for expanding and restructuring the education of professional health personnel, and the vital importance of adapting the education of health manpower to the changes needed for an effective system of delivery of health care in the United States." The Commission recommends that university health science centers be responsible, in their respective geographic areas, for coordinating the education of health-care personnel and for cooperating with other agencies and schools in improving the organization of health-care delivery. Their educational and research programs should become more concerned with problems of health-care delivery and the social and economic environment of health care. An important function, in cooperation with other schools and with professional associations in their areas, should be continuing education for all health manpower occupations. The Commission recommends also the development of area health education centers in areas at some distance from university-science centers which do not have sufficiently large populations and in a few metropolitan areas needing additional training facilities. These area centers would be affiliated with the nearest appropriate university health-science center and would perform somewhat the same functions, including continuing education programs for health manpower in the area, conducted in cooperation with local professional associations, colleges, and community colleges. The Commission

recommends the establishment of nine new university health science centers and 126 new area health education centers, to be located on the basis of careful regional planning. (See Item No. 393.) (RJB)

1. CONTINUING EDUCATION OF HEALTH MANPOWER
2. ADULT AND CONTINUING EDUCATION
3. PREPARATORY EDUCATION
4. HEALTH-CARE SERVICES

4.13 Better Use of Health Manpower

407. KISSICK, William L. "Effective Utilization: The Critical Factor in Health Manpower". *American Journal of Public Health.* Jan. 1968. Vol. 58, No. 1, pp. 23-29.

The author thinks that the United States can no longer justify the investment of years of education and training beyond high school in individuals who will subsequently devote significant portions of their time to routine duties that might be performed very effectively by people trained in half the time. We should stop thinking of manpower in terms of educational output and think of it in terms of the most precious resource to use to the fullest. Kissick looks at several approaches to better utilization such as the downward transfer of functions, education and training, career mobility and the use of technology. He also reviews obstacles to the use of manpower such as "consumer expectations," professional rigidities and credentialing, and comments on ways to lessen them. (RJB)

408. ROSEN, Sumner M. "Upgrading and New Careers in Health". *Social Policy.* Jan./Feb. 1971. pp. 15-24.

The premise of the author, an economist, is that the manpower shortage in the expanding health industry can be met by upgrading employees at the aide and orderly levels. Rosen recognizes formidable problems: the absence of a tradition for upgrading in the health occupations, licensure restraining task performance, the inflexible hierarchy of the industry, and an over-concern with professionalism. He considers programs for physician's and pediatrician's assistants, and for home health aides and New York City's Nurses' Aides Upgrading Programs. He discusses three studies: the Health Services Mobility Study, which aims to upgrade within present occupations; the "Systems Analysis" of Health and Hospital Service program at the Upjohns Institute; and the work at Albert Einstein College of Medicine, which attempts to build a model of an existing hospital and major medical school working together to offer a fully integrated career program. Rosen is optimistic that "the more effective any experiment with new careers is, the more critical those directly involved in it are likely to become of traditional manpower and training arrangements." He sees promise for change in the ideas of accountability, improved patient care, and consumer criticism. (MAP)

409. SOBEY, Francine. *The Nonprofessional Revolution in Mental Health.* Columbia Univ. Press, N.Y. 1970. 252 p.

Based on a nationwide survey of about 10,000 people in 185 government-sponsored programs, this book assesses how far the mental health profession has moved beyond the traditional medical model, with its relatively closed doctor-patient system, toward a broadly based public health intervention system. Encompassing various levels of mental health and disorder, this framework presents an approach which embraces prevention, treatment, and rehabilitation, and which entails coordinated planning with other community programs in health, education, and welfare. Attention is given to efforts to develop criteria for using both paid and volunteer nonprofessionals; types of projects and agencies; clientele groups served; and significant characteristics of nonprofessionals (including older adults, youth, minority groups, and persons with less than a high school education). Typical patterns of professional and nonprofessional work are also compared. Recruitment, training, and supervision are reviewed, followed by research findings on project goals and the extent of innovation. Evidence shows that nonprofessionals are providing valuable new services as well as taking on existing tasks. (ERIC/LY)

410. NELEIGH, Janice R. and others. *Training Nonprofessional Community Project Leaders.* Behavioral Publications, N.Y. 1971. 64 p.

This report of a five-year demonstration project, "Training Nonprofessional Community Project Leaders," conducted by Dona Ana Mental Health Services at Las Cruces, New Mexico, examines methods of selecting, assigning, training and giving consultation to nonprofessional mental health workers as they and the community developed specific health services. The Las Cruces area, in an economic and political flux, needed many mental health services but was without professional personnel to provide them. The nonprofessionals trained in this program (mental health project leaders) were second career people who had some related skills but they were not qualified mental health workers. Most of the trainees were women, who averaged 46 years of age, 2.5 years of college-level training, and 11.7 years of work experience. These nonprofessionals cooperated with the community to develop service projects (e.g., a school for retarded children, and a 24-hour crisis center), and then some of them became project directors. (MAP)

411. GARTNER, Alan *Paraprofessionals and Their Performance: A Survey of Education, Health, and Social Service Programs.* Praeger Publishers, N.Y. 1971. 174 p.

This book by the Associate Director of the New Careers Development Center analyzes the research on the paraprofessional in the fields of health, education, social science, corrections, and mental health. Gartner sees the role of the paraprofessional as being more than merely relieving the professional of some of his duties, and going on to reach hitherto unreached persons, to provide new services and to introduce the temper of the community into public agencies that have limited ties to the community. He discusses the paraprofessional as an agent of change, his role in reducing poverty and manpower shortages, his effect on colleges and credentialing, and, his role in bringing about upgrading and new careers. Gartner sees new kinds of workers, trained and utilized in new ways, as an answer to Dr. Sidney Garfield's call for a redesign of the present health delivery system. There is an extensive bibliography. (MAP)

412. FINE, Sidney A. *Guidelines for the Design of New Careers.* W. E. Upjohn Institute for Employment Research, Kalamazoo, Mich. 1967. 23 p.

This paper grew out of a workshop held for the Model Cities Conference on Manpower Development on June 15, 1967, and conducted by the New Careers Development Center of New York University. The author summarizes his guidelines: "The design of new careers involves technical and strategic considerations but, above all, employer and community commitment. It is commitment on the part of the employers that transforms dead-end jobs into opportunities for growth. This is fundamental. Once commitment is established, then technical and strategic guidelines become relevant. Technical guidelines include: (1) titling to reflect the commitment to a career (certain terms used in titles immediately signal the status of the job as an entry onto a career ladder); (2) selection procedures that recognize the range and development of potential and do not exclude on the basis of irrelevant and unnecessarily high criteria; (3) structuring of tasks to allow for higher functional attainment and increase of discretionary functioning; (4) supervision that implements the growing of people, as well as the achievement of production standards; (5) provision of regular increases in compensation to correspond with increased experience and competence; (6) provision of training and growth opportunities for those who can and need to achieve higher functional performance. Strategic guidelines include: (1) directing opportunities for new careers primarily at the poor and disadvantaged; (2) developing new careers primarily in the newly emerging community and health services work fields; (3) initiating new careers by resorting to both short- and long-term approaches, and especially avoiding assumptions that ignore the realities of professionalization." (RJB)

413. FINE, Sidney A. *Guidelines for the Employment of the Culturally Disadvantaged.* W.E. Upjohn Institute for Employment Research, Kalamazoo, Mich. 1969. 31 p.

The author summarizes his 12 guidelines: (1) Make a total commitment. (2) Put the reins in high-level hands. (3) Organize a training program for company personnel. (4) Pinpoint entry jobs for the culturally disadvantaged. (5) Interview; don't test. (6) Place the applicant on the job for which he is interviewed. (7) Coach to teach and reinforce adaptive skills. (8) Distinguish between prescribed and discretionary job content. (9) Teach specific content skills on the job; teach functional skills off the job but in the job environment.(10)Keep counseling in the background. (11) Contract out; don't try to do it all yourself. (12) Advance the worker as soon as feasible." (RJB)

414. FINE, Sidney A. *An Annotated Bibliography of Functional Job Analysis (FJA).* Human Sciences Research, Inc., McLean, Va. June 1965. 8 p.

415. GILPATRICK, Eleanor. *Suggestions for Job and Curriculum Ladders in Health Center Ambulatory Care: A Pilot Test of the Health Services Mobility Study Methodology.* City Univ. of New York. Research Foundation, N.Y. n.d. 169 p.

This is the report of The Health Services Mobility Study sponsored by the City University of New York. The study created a basic methodology to eliminate shortages by utilizing existing manpower in ambulatory patient care.

The HSMS system of job analysis has four components: task identification; the rating of each task on 16 skill scales; the rating of knowledge needed for each task within an organized system of knowledge classification; and the statistical manipulation of the task data so as to identify the interrelated skills and knowledge categories and then to identify task sequences based on the families of interrelated skills and knowledge. From these results job ladders are designed. (MAP)

416. MANPOWER ADMINISTRATION (DOL). *Handbook for Analyzing Jobs.* G.P.O., Washington, D.C. 1972. 345 p.

This document supersedes the *Training and Reference Manual for Job Analysis* and presents a new approach and structured procedure for obtaining and recording job-analysis data. Some of the major areas of use for job analysis are: recruitment and placement, better utilization of workers, job restructuring, vocational counseling, training, performance evaluation, and plant safety. This handbook deals with the analyses of jobs on a task or duty basis; the analyses are concerned with identifying actual work performed and the worker traits requirements basic for success in the activity. A related U.S. Department of Labor document is *A Handbook for Job Restructuring.* (MAP)

417. MANPOWER ADMINISTRATION (DOL) *A Handbook for Job Restructuring.* G.P.O., Washington, D.C. 1970. 46 p.

This handbook stemming from *A Handbook for Analyzing Jobs,* provides a basic guide for use in restructuring job systems for more efficient manpower utilization. Job restructuring is defined as "a special application of job analysis that involves the identification of jobs within the context of the system of which they are a part and the analysis and rearrangement of their tasks to achieve a desired purpose." The report notes that while employment opportunities are not available for many individuals, many jobs cannot be filled. The job restructuring techniques described here may alleviate this imbalance by providing opportunities for many individuals, together with career ladders and lattices. (MAP)

418. NAVY MEDICAL DEPARTMENT. *Job Analysis Techniques for Restructuring Health Manpower Education and Training in the Navy Medical Department.* G.P.O., Washington, D.C. 1972. Document No. AD 745-261.

The job analysis used a systems approach, in which 50 hospital corps and dental technician jobs were analyzed and restructured into 16 career ladders–from beginning levels to physician's assistant or technologist level. The report is available from the Department of Defense Documentation Center, Cameron Station, 5010 Duke St., Alexandria, Va. 22314. (RJB)

419. NATIONAL INSTITUTES OF HEALTH. Bureau of Health Manpower Education (DHEW) *Equivalency and Proficiency Testing: A Survey of Existing Testing Programs in Allied Health and Other Related Fields.* National Institutes of Health, Washington, D.C. 1971. 83 p.

This is the best single document surveying testing programs in allied health and other fields existing in 1971. It is available from the Division of Allied Health Manpower, or the U.S. Government Printing Office (1971:

432-628/3121). Its sections are "Testing Programs in the Medical Laboratory Field," "Testing Programs in Other Health Fields," "Testing Programs in Other Fields," and "Other Procedures." It has an annotated bibliography of 108 items (books, articles, theses, reports, unpublished papers, etc.). In 1972 the American Medical Association established a subcommittee on Proficiency and Equivalency Examinations. (RJB)

420. FOOD AND DRUG ADMINISTRATION. Consumer Protection and Environmental Health Service (DHEW). *The Health Educator Aide Program for Ghetto Areas.* G.P.O., Washington, D.C. 1968. 30 p.

The Health Educator Program provides for indigenous personnel as communication links with residents of urban slums; they visit the homes and teach basic principles of cleanliness and health. Frequently their work involves relationships between landlord and tenant or cooperation with other city departments. A pioneer program in Chicago was so successful as a communication system that the concept of Health Educator Aides is expanding in other directions. The person-to-person approach is an important but simple approach to ghetto problems but the program needs the support of overall city efforts and should be administered by a permanent community agency. (ERIC/DM)

421. AMERICAN HOSPITAL ASSOCIATION. *Health Education in the Hospital.* American Hospital Association, Chicago, Ill. 1965. 74 p.

This is the proceedings of an invitational conference conducted in Chicago, May 4-6, 1964, by the American Hospital Association and the Metropolitan Life Insurance Company, to discuss the potential role of hospitals in health education to the ill, their families and the community at large; "How can a hospital best meet health education needs at the community level?" Topics include: The Meaning of Educative Intervention: Axis for Community Health Education–the Hospital's Ambulatory Service; Some Questions about the Hospital's Responsibility; and Directions for Health Education in Hospitals. (MAP)

422. AMERICAN HOSPITAL ASSOCIATION. *Career Mobility Profiles.* American Hospital Association, Chicago, Ill. 1971. 17 p.

These 15 profiles from across the country of various approaches to the development of career mobility programs provide a sample of the health occupations for which such programs have been implemented. They encompass three categories of career-mobility programs: in hospitals, in neighborhood health centers, and in educational institutions. The document is intended to serve as a resource for planners of career mobility programs and should be used with another AHA publication, *Career Mobility: A Guide for Program Planning in Health Occupations.* This 1971 document is a guidebook for planning and operating career-mobility programs and contains the AHA's policy statement on career mobility, a rationale for career mobility programs, guidelines for managing these programs, and a glossary of career-mobility terms. (MAP)

423. AMERICAN HOSPITAL ASSOCIATION. *Career Mobility: A Guide for Program Planning in Health Occupations.* American Hospital Association, Chicago, Ill. 1971. 25 p.

This booklet was designed to guide health-care institutions, educational institutions and other interested agencies in planning and operating health-career mobility programs. It has sections on: the AHA's policy statement on career mobility; a rationale for career mobility; the guidelines for planning and implementing a career-mobility program, written for those who are responsible for the actual development and operation of the program; and a glossary of terms. A companion booklet, also prepared by AHA is *Career Mobility Profiles* (1971, 17 p.) gives essential information on 16 programs representing various approaches to career mobility in hospitals, neighborhood health centers and educational institutions. (RJB)

424. PERRY, J. Warren. "Career Mobility in Allied Health Education." *Journal of the American Medical Association.* Oct. 6, 1969. Vol. 210, pp. 107-110.

The author examines some of the needs for career mobility and some of the factors which might make it work, reports on a few attempts in operation, and asks, "Where do we go from here?" What is needed, he says, is a balance between education and job responsibilities. Some of the factors are: (1) a job description and thorough job analysis for each specific job level in each allied health program; (2) educational programs tailored to the role, functions and duties of each job and task; (3) core curricula; (4) equivalency and proficiency testing programs; (5) the breaking down of barriers between and among associations and agencies; (6) close relationships between community junior college programs at the associate degree and certificate level with the baccalaureate and graduate programs for the allied health professions. Perry cites efforts under way in these areas, most of them from his State, New York. He concludes, "The concept of career mobility will become a reality only when sufficient time and priority is given to deciding what the problems are in each field in attempting to prove or disprove the concept of vertical and horizontal mobility. Who should get into the act? It is quite certain that no formula derived by any resources other than the leadership group in the allied health professions themselves, working in collaboration with medicine, dentistry, nursing, and health educators, can bring this about." (RJB)

425. HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION (DHEW). *Training the Auxiliary Health Workers: An Analysis of Functions, Training Content, Training Costs, and Facilities.* G.P.O., Washington, D.C. 1968. 36 p.

The booklet describes what each type of worker is allowed to do and presents an overview of the substantive content of the training, length of training, training costs, and kinds of facilities and staff needed. The types of workers include community health aide, homemaker-home health aide, social worker aide, food service supervisor, physical therapy aide, medical record clerk, nursing assistant, licensed practical nurse (LPN), licensed practical nurse (advanced clinical), licensed practical nurse (public health), operating room technician (post-LPN training), medical aide (inhalation therapy), dental assistant, and purser-pharmacist mate. (ERIC/JK)

394. GARFIELD, Sidney R. "The Delivery of Health Care". *Scientific American.* April 1970. pp. 15-23. For annotation see numbered item.

426. HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION. National Center for Health Service Research and Development (DHEW). *Provisional Guidelines for Automated Multiphasic Health Testing and Services. Volume One.* G.P.O., Washington, D.C. 1970. 34 p.

In order to determine multiphasic health testing's validity, reliability and acceptability to patients and physicians, the National Center for Health Services Research and Development began a long-term project consisting of epidemiological, biomedical, economic behavioral, and technical investigations. Consultants, representing medicine, public health, health economics and finance, systems engineering, computer technology, and social and behavioral science met in a conference to distill the best of current knowledge and expertise in the form of provisional guidelines. Three volumes, aimed at physicians, administrators, consumer groups, commercial firms and third-party payers, are the product. Two other volumes present operational principles of Automated Multiphasic Health Testing and Services, and the proceedings of the Invitational Conference on AMHTS held on January 21-23, 1970 in Washington, D.C. (MAP)

427. BRODMAN, Keeve and van WOERKOM, Adrianus, J. "Computer-Aided Diagnostic Screening for 100 Common Diseases." *Journal of The American Medical Association.* Sept. 12, 1966. pp. 179-83.

This article gives the results of a study of the effectiveness of a multiple-screening method used to identify symptoms of 100 diseases frequently met in medical practice. A laboratory-type procedure, the Medical Data Screen (MDS), uses a questionnaire to collect comprehensive histories; the information is fed into a computer which categorizes and analyzes the historical facts. The researchers compared diseases identified by this method with those diagnosed by four internists and one general practitioner in the New York City area. The MDS method, which saves time, is impersonal, is easy to use, and has readily analyzed statistics, identified six out of any ten diseases, and seven out of any ten common diseases diagnosed in office patients by the participating physicians. "The chief usefulness of a method like MDS would appear to be in supplying information about the whole patient rather than solely about the present illness; thus the method has potential value in preventive medicine." Brodman and Van Woerkom give both the pros and cons of MDS. (MAP)

428. YARNELL, Stephen R., WAKEFIELD, Jay S. and McGOVERN, Richard E. *Acquisition of the Patient Database: A Review of Design Approaches, Performance, and Cost of Fifty-Five Different Systems.* Medical Computer Services Association, Seattle, Wash. 1971. 90 p.

This book is an analysis of 11 different design approaches for self-administered patient histories. Fifty-two different systems were evaluated within these 11 design approaches, and data are presented on each. The volume starts with one of the simplest approaches, paper-and-pencil questionnaires, and proceeds to more sophisticated computer-based systems.

The authors emphasize that they have deliberately expressed their opinions as candidly as possible on the relative merits of each approach and on the system that is the best example of each approach so that the report will be useful to physicians and health-care administrators as well as to manufacturers and service bureaus. (JAHA)

429. WAISBREN, Burton A. *Critical Care Manual: A Systems Approach Method.* Medical Examination Publishing Co., Flushing, N.Y. 1972. 89 p.

Waisbren writes that while there is a tendency to group critically ill patients in a hospital in an intensive-care area, it is unlikely that the majority of these patients have a trained physician in constant attendance. The purpose of this manual is to analyze the process of clinical decision-making and present it in such a way that would allow trained paramedical personnel to observe changes in patient condition and administer needed medications without constant physician attendance. This manual was developed during the treatment of critically ill patients suffering from severe burns, shock, overwhelming pneumonia, postoperative complications, and severe trauma. (MAP)

430. NATIONAL INSTITUTES OF HEALTH. Bureau of Health Manpower Education (DHEW). *Selected Training Programs for Physician Support Personnel.* G.P.O., Washington, D.C. 1971. 101 p.

This is a compilation of 125 programs for training new physician support personnel in 35 states as of March 1, 1971. Of these 47 extend nursing roles and 78 accept students with varied qualifications. Criteria for inclusion were: (1) The program was operational, in pilot testing stage, or in advanced planning; (2) as of March 1971 accreditation standards did not exist, were being developed, or were only recently developed; (3) admitted students must have completed high school or its equivalent and the program provided either short-term training for expanded roles or long-term training for entry-level positions, and (4) the resultant health professional would have identification differentiated from traditional health professions and would work under physician supervision. The outline format gives the institution, program directors, program title, stage of development, curriculum, degree or certificate, entrance requirements, number of enrolled students, and number of graduated students. (MAP)

431. SADLER, Alfred M., SADLER, Blair L. and BLISS, Ann A. *The Physician's Assistant: Today and Tomorrow.* Yale Univ. School of Medicine. Trauma Program of the Department of Surgery. Yale Univ. Press, New Haven, Conn. 1971. 256 p.

Alfred Sadler is a doctor, Blair Sadler is a lawyer, and Ann Bliss is a registered nurse. From these vantage points they see the physician's assistant as a development that could improve and extend health care but one that is facing many problems from inside and outside the health-care industry. Earlier chapters are prologue to chapter VI–"Issues and Recommendations." There is a selected bibliography of 197 books and articles organized by the chapters of the book: "Some Fundamental Concerns." "Lessons from Nursing," "Where the Law Intervenes," and "Organizational Alternatives." Eighty pages of appendices include HEW Guidelines for PA Programs, AMA List of PA Programs, the Brochure prepared by the National Commission for the Study of Nursing and Nursing Education "Nurse Clinician and Physician's Assistant:

The Relationship between Two Emerging Practitioner Concepts," Massachusetts Nurses Association Statement on the PA, the American Nurses' Association Statement on the PA, the New York State Nurses Association Statement on the PA, Excerpts from the 1965 ANA Position Paper, AMA Essentials for Approved PA Programs, Excerpt from AMA Report on Licensure, California Regulations of the PA, 1969 Colorado Child Health Associate Law, and the 1972 Amendment to the New York Nursing Practice Act. In brief, this is not only a book on the physician's assistant but also a small library. (RJB)

432. TODD, Malcolm C. and FOY, Donald F. "Current Status of the Physician's Assistant and Related Issues". *Journal of the American Medical Association.* June 26, 1972. pp. 1714-1720.

This article, written by the chairman of the AMA's Council on Health Manpower, and the director of the AMA's Department of Health Manpower, contends that, while the potential utilization of the physician's assistant is great, it is the responsibility of the medical profession to make sure that there is a rational development of physician-support personnel. The authors discuss the beginnings of the physician's assistant concept; organizational interest (the AMA, specialty colleges, and the Federal government); potential duties; patient and physician acceptance; education and certification; state legislation; the relationship of the physician's assistant to the medical assistant; and trends and prospects for the physician's assistant as a new national occupation. They refer the reader to "Answers to Specific Questions on Utilization of 'Physician's Assistants,'" available from the AMA Department of Health Manpower. (MAP)

433. MOSSEY, Jana and NICHOLSON, Sally. *Non-Physician Personnel in Ambulatory Child Health Care: A Review.* Univ. of North Carolina. Health Services Research Center, Chapel Hill, N.C. March 1971. 99 p.

Organization of services and types of personnel involved in giving child care have undergone many changes in recent years. Services rendered can no longer be described in terms of the hospital, the well child clinic and the doctor and the nurse. The review emphasizes trends in preparing and utilizing personnel for pediatric ambulatory care facilities. The material presented is a sample of existing patterns and proposed developments rather than a comprehensive presentation of all relevant programs. Two specific areas were explored: details of the care setting and the specifics of the function, supervision, and educational requirements of allied health workers. Child health care programs are moving toward comprehensive care in a location accessible to the patient and administratively answerable to community needs. Included is an annotated bibliography of 72 citations and 4 appendices. (HSRC)

434. HEALTH SERVICE REPORTS. "Try Nonphysician Health Team in Maryland HMO's". *Health Services Reports.* May 1972. pp. 443-444.

This describes a training program undertaken by Johns Hopkins Medical Institutions' Department of Maternal and Child Health to develop three-level, nonphysician family health teams to deliver comprehensive health care to families. Working within a health maintenance organization would be the

family health advocate (who acts as ombudsman), the family health associate (who processes health checkups and manages certain chronic illnesses), and the family health supervisor (who is responsible for diagnosis, treatment, and referral). The planners see the program as significant because it is designed to serve future health systems; it sets up a model for a manpower continuum in which preparation and utilization of different types of workers are optimally related; and it provides for horizontal mobility as well as vertical mobility. (MAP)

435. SCHLOTFELDT, Rozella M. "The Nurse's View of the Changing Nurse-Physician Relationship". *Journal of Medical Education.* Aug. 1965. pp. 772-777.

The author writes that physicians have long insisted upon education at the highest levels as preparation for medical practice and upon scientific inquiry for improving that practice. In contrast, nurses have only recently recognized that high-level education and scientific inquiry are essential. As a consequence of this uneven development, physicians rarely have the advantage of working with well-educated nurse-clinicians and clinical nursing specialists. Schlotfeldt's article describes the practitioner roles of the physician and professional nurse, identifies the elements of stability and change in their relationship, and points up some of the problems now being experienced. In solving these problems, the author suggests that medical and nursing personnel in medical centers investigate the roles of physicians and nurses, experimenting with planned changes and assessing the results of those changes. She warns that professionals should not stake out unwarranted claims on particular techniques and procedures; rather physicians and nurses must work together to solve society's current and future need for adequate health services. (MAP)

436. STANDARD, Raymond L. and EASLEY, Helen. "D.C.'s New Pediatric Nurse Practitioners". *Health Services Reports.* May 1972. pp. 387-391.

This describes a comprehensive 40-week pediatric nurse practitioner training program begun by the District of Columbia Department of Human Resources' Community Health Services Administration to prepare these professionals to assume a more independent role in the care of infants and children and to reduce the physician workload. The authors discuss recruitment for the pilot program, the training phases, responsibilities and duties of the practitioners, and the need for a permanent training center. (MAP)

437. SECRETARY'S COMMITTEE TO STUDY EXTENDED ROLES FOR NURSES. "Extending the Scope of Nursing Practice". *Nursing Outlook.* Jan. 1972. pp. 46-52.

This report to the Secretary of HEW surveys the extending outline of professional nursing practice in order to make recommendations for extending the role of nursing in the provision of health services. In each area of patient care (primary, acute, and long-term), elements of nursing are delineated as functions for which nurses are now generally responsible, functions for which nurses and physicians share responsibility, and functions for which many nurses are now prepared and could be prepared. Committee recommendations include the encouragement of collaborative efforts involving schools of medicine and nursing to offer programs demonstrating effective functional interaction of physicians and nurses; the undertaking of cost-benefit analyses to assess the impact of extended nursing practice on the health-care delivery

system; and the establishment of continuing education programs to prepare the present pool of over one million active and inactive nurses to function in extended roles. (MAP)

438. INTERAGENCY COMMITTEE ON DENTAL AUXILIARIES. "Report of the Interagency Committee on Dental Auxiliaries". *Journal of the American Dental Association.* May 1972. Vol. 84, pp. 1027-1047.

The Interagency Committee was established to assist the profession and its related groups in appraising attitudes and policy on utilization of dental auxiliary personnel. It was structured to provide representation of all agencies concerned with dental auxiliary education. This report contains a review of the history activity relating to dental auxiliary education and utilization, a statement of the Committee's philosophy, suggested guidelines for teaching dental auxiliaries expanded functions (through on-the-job training and structured continuing education programs), and recommendations for change in dental auxiliary education. (MAP)

439. HOFFNER, Alden N. and SHERMAN, Jerome. *A National Study of Assisting Manpower in Optometry.* [illegible]etric Center of New York, N.Y. 1971. 234 p.

This is the report of [illegible]y to determine the current number, duties, and education and training of ancillary optometric personnel and the projected need for such employees in order to provide job opportunities for the disadvantaged. The study describes the increasing public demand for quality eye care and the formal training needed to provide such care, and examines the possibilities of career ladders for technical occupations in optometry. The survey tool was a questionnaire sent to a national random sampling of member optometrists of the American Optometric Association. Several tables and appendices are given, including a tentative training program for optometric assistants. (MAP)

440. NATIONAL COMMITTEE FOR CAREERS IN MEDICAL TECHNOLOGY. *Manpower for the Medical Laboratory: A Summary Report.* G.P.O., Washington, D.C. 1968. 23 p. Health Service Publication No. 1771.

In October 1967, the National Conference on Education and Career Development of the National Committee for Careers in Medical Technology was held at College Park, Maryland on "Manpower for the Medical Laboratory." This is a compilation of significant statements and suggestions of the conference and symposium speakers and discussion groups. A fuller report of the conference can be found in *Manpower for the Medical Laboratory: The Proceedings.* (Public Health Service Publication No. 1833). (MAP)

AUTHOR INDEX

Compiled by June B. Brower